Supreme Court, U.S.
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No. 02

In The
Supreme Court of the United States

ALLINA HEALTH SYSTEM CORP., ET AL.,

Petitioners,

v.

UNITED STATES OF AMERICA, EX REL.
MINNESOTA ASSOCIATION OF
NURSE ANESTHETISTS,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

I. The False Claims Act, 31 U.S.C. §§ 3729-3733, bars a qui tam complaint based upon a prior public disclosure, unless the relator qualifies as an original source, defined as "an individual who has direct and independent knowledge" who "has voluntarily provided the information to the Government before filing an action. . . . " 31 U.S.C. § 3730(e)(4)(B) (1998).

A. Did the Eighth Circuit err in holding that respondent is an original source, despite the fact that it is a corporation, not an individual?

B. Did the Eighth Circuit err in imputing to respondent knowledge gained by its members while acting in the course and scope of their employment with defendant hospitals?

C. Did the Eighth Circuit err in concluding that respondent, which publicly disclosed its allegations before providing any information to the government, made the required pre-suit disclosure?

II. Did the Eighth Circuit err in finding an Article III case or controversy over alleged false claims that caused the government no injury?

III. Did the Eighth Circuit err in holding that respondent could prove defendants knowingly submitted false claims where no regulation prohibited the defendants' conduct, and where defendants relied on government advice that they were billing properly?

LIST OF PARTIES AND CORPORATE DISCLOSURE STATEMENT

Grouped by organizational affiliation, petitioners are Allina Health System, a Minnesota nonprofit corporation; Unity Hospital, Mercy Hospital, John Murphy, and Abbott Northwestern Hospital; and

Midwest Anesthesiologists, P.A., Metropolitan Anesthesia Network, and, in their individual capacity, Mark Sperry, M.D., Gary Baggenstoss, M.D., David Cumming, M.D., John Rydberg, M.D., Thelma M. Albay, M.D., Minda Castillejos, M.D., Teri Heil, M.D., Sang Hong, M.D., Ted Janossy, M.D., Raymond Kloepper, II, M.D., John Magdsick, M.D., Thomas Maggs, M.D., Thomas Polta, M.D., John Roseberg, M.D., Jai Suh, M.D., Jeffrey Yue, M.D.; and

Allen Tank and Health Billing Systems, Inc.; and

The St. Cloud Hospital; and

Anesthesia Associates of St. Cloud Ltd. and, in their individual capacity, Craig M. Johnson, M.D., Gary A. Boeke, M.D., Philip F. Boyle, M.D., L. Michael Espeland, M.D., Alan D. Espelien, M.D., Paul J. Halverson, M.D., Lanse C. Lang, M.D., A. Wade McMillan, M.D., William H. Rice, M.D., Alan A. Reitz, M.D., and Annette E. Zwick, M.D.; and

Anesthesiology, P.A; and

Northwest Anesthesia, P.A. and, in their individual capacity, Bryce Beverlin, M.D., Richard Blomberg, M.D., Jean Boening, M.D., Mitchell Burke, M.D., Rajarao Dwarakanath, M.D., Richard Engwall, M.D., James

LIST OF PARTIES AND CORPORATE DISCLOSURE STATEMENT – Continued

Gayes, M.D., Luis Giron, M.D., Nancy Groves, M.D., Jonathan Gudman, M.D., Richard Johnson, M.D., John Lillehei, M.D., Robert McKlveen, M.D., Judith Meisner, M.D., M. Michael Menzel, M.D., James Musich, M.D., Mark Nissen, M.D., Xavier Pereira, M.D., David Plut, M.D., Jeffrey Shaw, M.D., Richard Skoog, M.D., William Stauffer, M.D., Ofelio Tiu, M.D., Robert Tronnier, M.D., and John Wintermute, M.D.

None of the petitioners have parent companies and no publicly held company has any financial interest in any of the petitioners.

The respondent is the Minnesota Association of Nurse Anesthetists, a nonprofit corporation, incorporated in Minnesota.

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PETITION FOR WRIT OF CERTIORARI

Petitioners Allina Health System, et al., respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eighth Circuit, entered in *United States ex rel. Minnesota Ass'n of Nurse Anesthetists v. Allina Health System Corp.*, on Jan. 17, 2002.

OPINIONS AND ORDERS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit is reported at *United States ex rel. Minnesota Ass'n of Nurse Anesthetists v. Allina Health System Corp.*, 276 F.3d 1032 (8th Cir. 2002), and is reprinted in the appendix at App. 1. The opinion of the United States District Court for the District of Minnesota, granting all defendants summary judgment, is reported at 1999 U.S. Dist. LEXIS 23036 (D. Minn. March 16, 1999), and is reprinted in the appendix at App. 49.

JURISDICTION

On March 25, 2002, the Eighth Circuit denied the petition of Allina Health System, et al., for rehearing and/or rehearing en banc. Petitioners invoke the jurisdiction of this Court under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

False Claims Act, 31 U.S.C. §§ 3729-3733, reprinted at App. 85-118.

Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812, reprinted at App. 118-148.

42 C.F.R. § 414.46(c)(1)(iv), reprinted at App. 151-152.

42 C.F.R. § 414.46(d)(3), reprinted at App. 153-154.

42 C.F.R. § 414.451 (1992), published in 57 Fed. Reg. 33898-99 (July 31, 1992), reprinted at App. 154.

42 C.F.R. § 405.552 (1991), published in 48 Fed. Reg. 8938 (March 3, 1983) and amended at 48 Fed. Reg. 39830 (September 1, 1983), reprinted at App. 157.

STATEMENT OF THE CASE

Anesthesia services in hospital operating rooms are commonly provided by a combination of two different types of anesthesia providers – physician anesthesiologists and certified registered nurse anesthetists ("CRNAs"). In the anesthesia care team approach used by hospitals nationwide, a CRNA stays in each operating room with the patient, while an anesthesiologist moves from room to room, providing service to one or more patients concurrently.

The relator's allegation in this case is that the defendants, through their bills to Medicare for providing anesthesia services, knowingly submitted false claims to the United States government in violation of the False Claims Act, 31 U.S.C. §§ 3729-3733 ("FCA").

In the 1990s, hospitals across the country restructured their anesthesia departments in order to provide anesthesia services more efficiently. As a result, CRNAs often were no longer employed directly by hospitals, but became employees of, or subcontractors to, practice groups of physician anesthesiologists. This restructuring resulted in no change in the way care was provided to patients, but did change employment relationships.

The Minnesota Association of Nurse Anesthetists ("MANA") is the incorporated trade association of CRNAs

in Minnesota. It opposed this trend in employment structure as impinging on its CRNA members' professional freedom.

In March 1994, two suburban Twin Cities hospitals, defendants Unity and Mercy Hospitals, which are owned and jointly operated by defendant Allina Health System ("Allina"), underwent a reorganization that resulted in CRNAs subcontracting with defendant Midwest Anesthesiology, P.A., to provide CRNA services at those hospitals. In early November 1994, the independent St. Cloud Hospital, in St. Cloud, Minnesota (approximately 80 miles northwest of the Twin Cities) initiated a similar reorganization that resulted in CRNAs leaving the employ of the hospital and becoming employees of defendant Anesthesia Associates of St. Cloud Ltd.

On November 8, 1994, MANA and several individual nurse anesthetists filed an antitrust action in federal court against the hospitals and the anesthesiologists practicing at them. App. 159. MANA alleged that the anesthesia department reorganizations were a conspiracy in restraint of trade, and were in some way designed to cover up or to divide the fruits of false claims to Medicare for anesthesia services.

Throughout the antitrust complaint, MANA repeatedly alleged that the physicians and hospitals it had sued had submitted false claims for anesthesia services provided to Medicare patients. The opening paragraph of that complaint alleged "fraudulent billing in violation of various State and Federal Medicare statutes." Further allegations of false claims to Medicare appeared in paragraphs 44-46, 51-53 and 66 and 68 of the antitrust complaint. App. 171-172; 174. The press widely reported

MANA's allegations of false Medicare claims. App. 201; App. 203.[1]

Seven weeks after filing the antitrust action, with its attendant burst of publicity, MANA filed this qui tam action under the FCA. App. 206. The nonprofit corporation MANA was the sole relator. The initial defendants in the FCA action were the same hospitals and anesthesiologists as in the antitrust action, as well as Anesthesiology, P.A., the anesthesiologist group practicing at North Memorial Hospital, an independent hospital in Minneapolis.[2] After the qui tam action was filed, Abbott Northwestern Hospital in Minneapolis, also owned by Allina, reorganized its anesthesia department. MANA then amended its complaint to include that hospital and the anesthesiologist group practicing there, Northwest Anesthesia, P.A., and 25 of its physician members. MANA ultimately named 65 defendants at five hospitals in four Minnesota cities, alleging over $1 billion in damages and FCA fines and penalties. App. 319.

MANA mailed a copy of the antitrust action complaint to a Medicare office on November 14, 2002, a week after it was publicly filed and its allegations disclosed in the press. This was MANA's only disclosure to the government of the information on which it based its FCA claims before it filed the qui tam action. The government declined to intervene.

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[1] Ultimately, the district court granted summary judgment to all defendants in MANA's antitrust action, a judgment that the Eighth Circuit affirmed. *Minnesota Ass'n of Nurse Anesthetists v. Unity Hosp.*, 208 F.3d 655 (8th Cir. 2000) ("*MANA II*"). *See also Minnesota Ass'n of Nurse Anesthetists v. Unity Hosp.*, 59 F.3d 80 (8th Cir. 1995) ("*MANA I*") (vacating preliminary injunction).

[2] North Memorial was, at the time, considering reorganizing its anesthesia department.

MANA ultimately alleged that the anesthesiologist defendants submitted three categories of false claims: (1) billing Medicare for personal performance of single non-concurrent cases involving both an anesthesiologist and a CRNA (so-called "1:1" or "AA modifier" cases) when the anesthesiologist was present in the operating room for some but not all of the procedure with the CRNA, App. 256-257; (2) billing Medicare for medical direction of concurrent procedures when the anesthesiologist allegedly failed to participate in the patient's emergence from anesthesia App. 249-250; and (3) billing Medicare for medical direction of concurrent procedures when the anesthesiologist misidentified the number of concurrent procedures occurring, App. 256-257; 270; 247-248. In no case did MANA allege that a patient had received unnecessary anesthesia care.

MANA also alleged that the hospital defendants (Allina and its hospitals and the St. Cloud Hospital) billed Medicare "under an improper modifier" for services of employee CRNAs in cases where both an anesthesiologist and a CRNA were medically necessary – a claim that essentially amounted to an allegation of false underbilling. App. 300-301. Finally, MANA alleged that every defendant had conspired with every other defendant to get false claims paid. App. 320-321.

After lengthy discovery, all defendants moved for summary judgment. The district court granted defendants' motion. App. 60.

A panel of the Eighth Circuit affirmed the portion of the district court's judgment dismissing MANA's conspiracy claims and reversed the remainder. App. 1.

REASONS FOR GRANTING THE WRIT

Petitioners respectfully request that this Court grant certiorari because the decision of the United States Court of Appeals for the Eighth Circuit contradicted established law in numerous respects. The Eighth Circuit: (1) injected its own policy preference for a broad class of "original source" relators rather than applying the statutory language chosen by Congress; (2) improperly allowed a corporate entity to proceed as an original source relator; (3) created a split in the circuits on the pre-suit disclosure requirements in the FCA; (4) unconstitutionally asserted federal jurisdiction over MANA's claims against the hospitals; and (5) created a split in the circuits by reversing the district court's grant of summary judgment where no regulation prohibited the conduct alleged to have resulted in false claims, and the undisputed record showed that the defendants had followed contemporaneous government guidance in submitting the claims at issue. All of these errors rise to a level justifying this Court's review of the Eighth Circuit's judgment.

The Court should grant the petition because this case exemplifies the damage that can be done to health care providers as a result of improperly extending the jurisdictional and substantive reach of the FCA. The number of qui tam suits filed against health care providers has mushroomed since the FCA was amended in 1986. Thirty-three qui tam suits were filed in the year after the amendments, while 483 were filed in fiscal year 1999. Almost half of these qui tam filings involved the health care industry. App. 349-352.

Because of the complexity of the federal Medicare regulations, the Department of Justice has cautioned against the potential for abuse in FCA actions against

health care providers. In 1998, Deputy Attorney General Eric H. Holder, Jr., issued *Guidance on the Use of the False Claims Act in Civil Health Care Matters*. App. 353. In that Guidance, Mr. Holder urged Department of Justice attorneys to consider carefully whether billing errors constitute actual fraud. The Guidance also stated that it is important to determine whether a provider had sought guidance from the program agency or its agents, whether the guidance provided was clear, and whether the providers relied on the guidance in making claims. App. 357. The Department of Justice's recognition of the impropriety of pursuing false claims litigation against providers that, like the defendants, relied upon government guidance in submitting Medicare claims also applies to private relators proceeding under the qui tam provisions of the FCA.

I. THE FEDERAL COURTS LACK SUBJECT MATTER JURISDICTION OVER THIS ACTION BECAUSE MANA IS NOT AN "ORIGINAL SOURCE"

Congress provided the qui tam vehicle as an inducement for those with knowledge of false claims to come forward and allow the government an opportunity to recover improperly paid claims for money. *See* H.R. Rep. No. 99-660, at 17 (1986); S. Rep. No. 99-345, at 2 (1986). *See also Vermont Agency of Natural Res. v. United States ex rel. Stevens*, 529 U.S. 765, 773-78 (2000) (discussing history and purpose of qui tam actions); *United States ex rel. McKenzie v. BellSouth Telecomm., Inc.*, 123 F.3d 935 (6th Cir. 1997); *United States ex rel. Barth v. Ridgedale Elec., Inc.*, 44 F.3d 699 (8th Cir. 1995). MANA has instead used the FCA as a tool in its marketplace battle with the medical profession. App. 72-73. Congress restricted the

jurisdictional reach of the FCA to prevent such abuses of the qui tam mechanism.

The FCA, in 31 U.S.C. § 3730(e)(4), provides that federal courts lack subject matter jurisdiction over:

> an action . . . based upon the public disclosure of allegations or transactions . . . unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

This statutory restriction on federal jurisdiction is to be strictly construed and doubts resolved against expanding federal jurisdiction. *See, e.g.*, *Horton v. Liberty Mut. Ins.*, 367 U.S. 348, 357 (1961) ("[T]his Court has repeatedly held that [federal] jurisdiction is to be narrowly interpreted.").

Here, the Eighth Circuit affirmed the district court's finding that MANA's qui tam complaint was based upon the earlier public disclosures embodied in the antitrust complaint and the news reports surrounding the filing of that complaint. In so doing, the Eighth Circuit followed "[t]he majority view . . . that a qui tam suit is 'based upon' a public disclosure whenever the allegations in the suit and in the disclosure are the same, 'regardless of where the relator obtained his information.'" App. 22-23, quoting *United States ex rel. Doe v. John Doe Corp.*, 960 F.2d 318, 324 (2d Cir. 1992), and citing, *inter alia*, *United States ex rel. Findley v. FPC-Boron Employees' Club*, 105 F.3d 675, 682-85 (D.C. Cir. 1997), and *McKenzie v. BellSouth*, 123 F.3d at 940.[3] The Eighth Circuit, however, impermissibly

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[3] Only the Fourth Circuit continues to apply a more restrictive definition of "based upon." *See United States ex rel. Siller v. Becton Dickinson & Co.*, 21 F.3d 1339, 1348 (4th Cir. 1994).

deviated from the language of the FCA in determining that MANA was an "original source" entitled to pursue a qui tam action.

A. MANA Is Not "An Individual"

In the FCA, Congress defined "original source" as:

> *an individual* who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under this section which is based on the information.

31 U.S.C. § 3730(e)(4)(B) (emphasis added). MANA is an incorporated trade association. The Eighth Circuit erroneously held that MANA is "an individual," dismissing the language chosen by Congress in a footnote. App. at 29-30

In construing a term in a statute, "[t]he first step is to determine whether the language at issue has a plain and unambiguous meaning with regard to the particular dispute in the case." *Barnhart v. Sigmon Coal Co.*, 122 S. Ct. 941, 950 (2002) (citing *Robinson v. Shell Oil Co.*, 519 U.S. 337, 340 (1997)). "The inquiry ceases 'if the statutory language is unambiguous and the statutory scheme is coherent and consistent.'" *Id.* In *Barnhart*, the Court noted that it has stated,

> time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there. When the words of a statute are unambiguous, then, this first canon is also the last: 'judicial inquiry is complete. . . .' We will not alter the text in order to satisfy the policy preferences of the [party].

Id. at 956 (quoting *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992)).

The Eighth Circuit concluded that "individual" in the FCA's original source provision encompassed not only human beings but also collective organizations such as trade associations and corporations. In so holding, the Eighth Circuit essentially equated the legal meaning of the term "individual" with "person," and nullified the distinction between the two terms.

In the Dictionary Act, 1 U.S.C. § 1, Congress stated that "in determining the meaning of any Act of Congress, unless the context indicates otherwise . . . the word [ ] 'person'. . . include[s] corporations, companies, associations, firms, partnerships, societies, and joint stock companies, as well as individuals." Unquestionably, Congress intended for the term "person" to be broader than "individual." "Person" is a class, and the enumeration following "person" comprises, but does not exhaust, the class. *See Sutherland Statutory Construction*, § 47:18 (6th ed. 2002). An "individual" is only one example of a "person." Any other interpretation would render Congress's decision to use the term "individual" in the FCA original source provision, rather than "person," superfluous. This Court has held that in such instances, the doctrine of *ejusdem generis* applies to reconcile any incompatibility so that all words in a statute can be given effect and none will be superfluous. *See Breiniger v. Sheet Metal Workers Int'l Ass'n Local Union No. 6*, 493 U.S. 67, 92 (1989) (citing *Sutherland's Statutory Construction*, § 47:17 (4th ed. 1984). Equating the two terms, as the Eighth Circuit's decision does, strips the term "individual" of the independent meaning Congress gave it.

Additionally, the Eighth Circuit ignored this Court's recent holding in *Stevens*, which has a direct bearing on the meaning of the words "individual" and "person" in the

FCA. In *Stevens*, this Court held that "person" as used in Section 3729 of the FCA has the same meaning as "person" in its "sister act," the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812 ("PFCRA"). 529 U.S. at 786 and n.17.[4] PFRCA defines "person" as "any individual, partnership, corporation, association, or private organization." *Id.* (citing 31 U.S.C. § 3801(a)(6)). Thus, the definition of "person" in PFCRA is also the definition of "person" in the FCA. In both statutes, the term "individual" is clearly confined to its plain meaning of a human being.

In *Barnhart*, 122 S. Ct. at 956, this Court recently reiterated that federal courts are not free to ignore the statutory language chosen by Congress in pursuit of other policy objectives, as the Eighth Circuit did here in its interpretation of the FCA's original source provision. In disregarding Congress's language, the Eighth Circuit expressed an impermissible policy preference for a broader universe of "original source" relators than Congress defined.

The Eighth Circuit opined that Congress could not have intended to preclude organizations from acting as FCA relators because "any such rule would have disqualified the State of Wisconsin from proceeding as relator in [*United States ex rel. Wisconsin v.] Dean*[, 729 F.2d 1100

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[4] The PFCRA and the FCA are statutes *in pari materia* and should be construed together. *See Sutherland Statutory Construction*, § 51:01 (6th ed. 2002); *Maryland v. Garrison*, 480 U.S. 79, 83-84 (1987). This Court in *Stevens* stated that "there is no question that the PFCRA was designed to operate in tandem with the FCA. Not only was it enacted at virtually the same time as the FCA was amended in 1986, but its scope is virtually identical to that of the FCA." *Stevens*, 529 U.S. at 786 n.17.

(7th Cir. 1984)]." App. 32. The Eighth Circuit misconstrued Congress's intent in amending the FCA to address the *Dean* case.

Congress permits relators to be "persons." 31 U.S.C. § 3730(b). In those cases where the allegations underlying a private civil action have been publicly disclosed, however, Congress specifically reserved the right to proceed as qui tam relators to one single category of persons – "an individual." 31 U.S.C. § 3730(e)(4)(B). This deliberate distinction represents a careful balancing of Congress's interest in encouraging private attorneys general but discouraging those who would profit from information already in the public domain. As to the *Dean* case, this Court explicitly left open in *Stevens* the question of whether a state could be a relator in an FCA case. 529 U.S. at 787 n.18. The original source provision of the Act does not preclude such a result (although the language of that provision would preclude states from proceeding as relators if the action was based upon a public disclosure).[5]

To support its expansive definition of "individual" despite Congress's clear and unambiguous language, the

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[5] The *Dean* case focused on the fact that Wisconsin had provided evidence of the false claims at issue to the federal government. Under the FCA as it existed at the time, this disclosure was sufficient to bar the state from proceeding with a qui tam action. *Dean*, 729 F.2d at 1103, citing 31 U.S.C. § 232(c). In the 1986 FCA amendments, Congress removed the bar to qui tam suits merely because the federal government might have somewhere in its files information on which the action is based. Congress also comprehensively rewrote the subject matter jurisdiction provisions of the FCA, enacting 31 U.S.C. § 3730(e). But nothing in the legislative history to the 1986 amendments indicates that when Congress defined an original source as "an individual," the word was not intended to have its plain meaning.

Eighth Circuit improperly relied on *Clinton v. City of New York*, 524 U.S. 417, 429 (1998). In *Clinton*, this Court recognized that "individual" usually refers to a "single human being," but "person" "often has a broader meaning in the law." 524 U.S. at 428 n.13. This Court deviated from the general rule with regard to the Line Item Veto Act in the *Clinton* case only because other factors revealed that Congress intended to expedite a constitutional challenge to that statute by any injured party.[6] Those factors are not present in this case. The *Clinton* holding that "individual" and "person" are interchangeable in the Line Item Veto Act is a narrow exception to the general rule and must be confined to that case. The more recent *Stevens* holding reaffirms the general rule that the two terms are not interchangeable, and expressly applies that decision to the FCA.

This Court should correct the Eighth Circuit's clear error in deviating from the plain meaning of "individual." The Eighth Circuit impermissibly created federal subject matter jurisdiction where Congress intended to foreclose jurisdiction.

B. MANA Did Not Have "Direct Knowledge" Of The Information On Which Its Allegations Were Based

To qualify as an "original source," the FCA also requires that a relator have "direct and independent knowledge of the information on which the allegations are

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[6] Justice Scalia, joined by Justice O'Connor, partially dissented in *Clinton*, arguing against judicial creation of an exception to the long established definition of "individual." Relying on the Dictionary Act, 1 U.S.C. § 1, the dissenters wrote that "corporations, cooperatives, and governmental entities are not 'individuals' under any accepted usage of that term." *Clinton*, 524 U.S. at 454.

based." 31 U.S.C. § 3730(e)(4)(B). The Eighth Circuit concluded that MANA's knowledge was direct because it came from its members and, as a "voluntary unincorporated trade association," MANA had no legal status apart from its members. App. 32. The Eighth Circuit erred. MANA is a nonprofit corporation.[7] App. 363-382. Unlike an unincorporated association, the knowledge of members of a nonprofit corporation is not automatically attributable to the corporation. The member must be an authorized agent. *See, e.g., Fletcher's Cyclopedia Corporations*, Vol. 3 § 814 (Perm. ed. 1994) ("the shareholders of a corporation, individually, are not its agents"); *State v. North Star Research and Dev. Inst.*, 200 N.W.2d 410, 414 (Minn. 1972) ("[nonprofit] members serve the same function that shareholders in a profit corporation serve"). The knowledge of CRNAs, who were hospital employees when they observed allegedly false claims, cannot be imputed to MANA merely because of their membership in the nonprofit corporation.

In support of its argument that MANA acquired its "direct" knowledge from its members, the Eighth Circuit relied on *United States ex rel. Springfield Terminal Ry. v. Quinn*, 14 F.3d 645 (D.C. Cir. 1994). App. 31. *Springfield*, however, involved corporate employees who indisputably acted within the course and scope of their employment when they detected false claims. If a corporate entity could ever qualify as an original source, it could do so only because the knowledge imputed to it from its employee agents was direct. Here, in contrast, MANA's members were acting within the course and scope of their employment with the *hospitals* when they allegedly observed

[7] MANA did not inform the Eighth Circuit of its corporate status.

false claims. *See MANA I*, 59 F.3d at 83. They were not employed by or acting on MANA's behalf.

Circuit courts in *Federal Recovery Services, Inc. v. United States*, 72 F.3d 447 (5th Cir. 1995), and *United States ex rel. Precision Co. v. Koch Indus., Inc.*, 971 F.2d 548 (10th Cir. 1992), found that corporate relators were not original sources. The Eighth Circuit incorrectly distinguished these cases on the grounds that the corporate relators were formed after discovery of the alleged false claims. App. 31-33. The Eighth Circuit's analysis of these cases, however, did not address the dispositive issue – whether the individuals with direct knowledge of the alleged false claims were acting as agents of the purported original source at the time they obtained that knowledge. The corporations in *Federal Recovery* and *Precision Co.* were not original sources because the individuals actually possessing the knowledge were not agents of the corporation – the date on which the corporations were established was merely proof of that fact.

The distinction between *Springfield* and this case is easily highlighted by a hypothetical: If the Springfield Railway employees had been members of the Sierra Club, could the Sierra Club also have qualified as an original source in that case? Of course not. The direct knowledge of an individual is not attributable to any organization of which she happens to be a member. At most, an individual's knowledge is imputed to the organization – usually an employer – for which she is an authorized agent. The individual CRNA members of MANA were not its authorized agents merely because they were members, and the Eighth Circuit impermissibly permitted MANA to proceed as an original source relator when it had no direct knowledge of the alleged false claims.

C. The Eighth Circuit Deviated From Other Circuits On The FCA's Pre-suit Disclosure Requirements

The Eighth Circuit concluded that the pre-suit disclosure to the government required for an individual to qualify as an original source need not precede public disclosure of the false claim allegations. App. 35 In so holding, the Eighth Circuit rejected the analysis of the D.C. Circuit in *Findley* and the Sixth Circuit in *McKenzie*, both of which have held that in order to be an original source, the relator must provide the information supporting its allegations to the government before the public disclosure. *See Findley*, 105 F.3d at 690 ("[i]t is clear to us that an 'original source' must provide the government with the information prior to any public disclosure"); *McKenzie*, 123 F.3d at 942 (following *Findley*, and stating, "[w]e find it difficult to understand how one can be a 'true whistleblower' unless she is responsible for alerting the government to the alleged fraud before such information is in the public domain"). Ironically, in view of its action in deviating from the plain meaning of the FCA's language in interpreting the terms "individual" and "direct . . . knowledge" in the original source provision, the Eighth Circuit justified its split with the Sixth and D.C. Circuits on the pre-suit disclosure portion of that provision by claiming fidelity to congressional choice of language. App. 34-35.

The interpretation of the Sixth and D.C. Circuits is consistent with the goal of the FCA of encouraging those with knowledge of fraud to come forward at the earliest possible time and to discourage persons with relevant information from remaining silent. The legislative history of the 1986 amendments to the FCA expressly confirms that Congress intended to require a potential relator to

voluntarily provide his information to the government before any public disclosure occurred in order to qualify as an original source. One of the principal sponsors of the amendments stated:

> A person is an original source if he had some of the information related to the claim which he made available to the government or the news media *in advance of the false claims being publicly disclosed.*

132 Cong. Rec. 29322 (1986) (statement of Rep. Berman) (emphasis added).[8] The decisions in *McKenzie* and *Findley* accurately reflect this congressional intent.

The requirement that a putative original source disclose information in his possession to the government before its public disclosure serves to prevent those relators who add nothing to the government's ability to analyze a case from taking a portion of the government's award under the FCA. The public interest goals of the FCA are not advanced by rewarding relators who bring nothing new to the table. *See* Robert Salcido, *The Public Disclosure Bar of the False Claims Act*, Health Care Fraud Litigation Reporter, Vol. 7, Issue 8 (April 18, 2002) (criticizing the Eighth Circuit's contrary holding).

MANA's provision of information to the government constituted the merest feint at compliance with the FCA's pre-suit disclosure requirement. The only "information" MANA provided the government before filing the qui tam action was a copy of the antitrust complaint, which was

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[8] Rep. Berman added this explanation to the amendments' legislative history on October 7, 1986, when the House of Representatives agreed to adopt the Senate's version of the bill containing what is now the current language of the "original source" provision. 132 Cong. Rec. 29315, 29322; *compare id.* at 29317 *with* 31 U.S.C. § 3730(e)(4).

already in the public domain and the subject of newspaper reports. MANA brought nothing to the government's attention that was not already publicly available and added nothing to the government's ability to evaluate and act on the claim.

The Eighth Circuit's decision creates a split among the circuits that this Court should resolve. MANA could not qualify as an original source in the Sixth or D.C. Circuits. The Eighth Circuit's ruling expands federal subject matter jurisdiction under the FCA beyond the limits applied in other circuits and intended by Congress.

II. MANA LACKS ARTICLE III STANDING TO PURSUE CLAIMS AGAINST THE HOSPITAL DEFENDANTS BECAUSE THEIR CONDUCT CAUSED THE GOVERNMENT NO INJURY

Among "the irreducible constitutional minim[a] of standing" is the requirement that the plaintiff have suffered "injury in fact." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992). Under the FCA, for a private relator to have standing to pursue a civil qui tam action, the United States must suffer "proprietary injury resulting from the alleged fraud." *Stevens*, 529 U.S. at 771. The sole basis for the relator's standing to assert the government's rights is via a "partial assignment of the Government's *damages* claim." *Id.* at 773 (emphasis added). The measure of damages is not simply what the alleged offender billed, it is "'the amount that [the government] paid out by reason of the false statements over and above what it would have paid if the claims had been truthful.'" *United States v. Cooperative Grain & Supply Co.*, 476 F.2d 47, 62 (8th Cir. 1973), quoting *United States v. Woodbury*, 359 F.2d 370, 379 (9th Cir. 1966).

In this case, the Eighth Circuit affirmed the district court's grant of summary judgment on MANA's claim of conspiracy. With the conspiracy claim dismissed, the only claim remaining against the hospital defendants is a claim for allegedly *underbilling* Medicare for CRNA services in complex cases where Medicare agreed to pay for the services of both an anesthesiologist and a CRNA – so-called "medical necessity" cases. App. 300-301. MANA as a private relator lacks standing to pursue such a claim.

The district court correctly identified that to have standing to pursue an FCA claim against the hospital defendants, a private plaintiff must "demonstrate the existence of a material fact," as to the "amount of damages which the Government sustains *because of the act of that person. . . .*" App. 75, quoting 31 U.S.C. 3729(a) (emphasis added). *Cf. United States v. Bornstein*, 423 U.S. 303, 313 (1976) ("A correct application of the [FCA's] statutory language requires . . . that the focus in each case be upon the specific conduct of the person from whom the Government seeks to collect the statutory forfeitures.").

The regulations under which the hospitals billed for CRNA services on medical necessity cases provided for two levels of service, or "modifiers": a lower medically directed rate; and a higher non-medically directed rate. *See* 42 C.F.R. § 414.451(a)(1) and (2), published in 57 Fed. Reg. 33898-99 (July 31, 1992), and 42 C.F.R. § 414.46(d)(3).

MANA alleged that hospital-employed CRNAs provided anesthesia services with respect to the "medical necessity" cases. App. 300-301. There is no dispute that the Medicare carriers for Minnesota directed the hospitals to bill these cases at the lower medically directed rate, a policy that saved the government money. App. 383-384.

The district court carefully held MANA to the summary judgment standard:

> Presumably, Plaintiff argues that the hospitals should have billed these cases at a higher, non-medically directed rate. . . . *Plaintiff has not responded to this aspect of Defendants' argument* [(emphasis added)]. When viewing Plaintiff's claims with regard to the medical necessity cases, there is no identified damage to the United States Government. The apparent thrust of Plaintiff's claim is that the Defendant hospitals were *underbilling* Medicare when using the improper modifier of "medically directed."

App. 75-76. MANA presented no evidence that the hospitals' billing, considered alone, had caused the government to pay more for the hospitals' services, including services of employee CRNAs, than it should have.

The hospital defendants' liability must be judged only by the alleged damages attributable to their own billing, 31 U.S.C. § 3729(a), not by the alleged misbilling of the independent physicians. "The Act, in short, penalizes a person for his own acts, not for the acts of someone else." *Bornstein*, 423 U.S. at 312.

Because the hospital defendants' charges for CRNA services were at the lower of the only two available rates, the hospitals' actions caused no fiscal injury to the government. As this Court held in *Stevens*, a private qui tam relator lacks Article III standing to pursue a civil claim in such circumstances.

III. THE EIGHTH CIRCUIT'S RULING THAT A RELATOR MAY PROCEED WHERE NO STATUTE OR REGULATION PROHIBITS THE CHALLENGED CONDUCT AND WHERE DEFENDANTS BILLED CONSISTENTLY WITH GOVERNMENT ADVICE HAS NATIONAL IMPORTANCE

The Eighth Circuit's ruling clears the way to trial for any relator who alleges that a health care provider submitted false claims, even when the conduct at issue is not prohibited by Medicare's payment regulations and even when the government itself agreed contemporaneously with the health care provider's interpretation of the regulations. Health care providers nationwide already struggle to comply with Medicare's byzantine regulations and face regular cutbacks in Medicare reimbursement. Now they also face the specter of exorbitant liability for allegedly violating nonexistent regulatory prohibitions.

This case presents an issue of nationwide importance. Contrary to several other circuits, the Eighth Circuit erroneously required the defendants to prove their compliance with phantom rules that have never been written or adopted, instead of requiring MANA first to produce evidence that each defendant knowingly billed contrary to established rules. In this respect, the Eighth Circuit's decision contains two fundamental errors of statutory construction relating to falsity and intent that have wide-ranging significance for all False Claims Act cases.

First, the Eighth Circuit erroneously held that a defendant who engages in conduct not defined or prohibited by any regulation may nonetheless be found to have submitted false bills by reason of such conduct. App. 40. In so holding, the Eighth Circuit has set the Act's "falsity"

requirement adrift by divorcing it from any requirement to prove that a defendant violated a specific legal standard.

Second, the Eighth Circuit erroneously held that a defendant who has billed consistently with and in reliance on the government's guidance may still be held liable for "knowingly" submitting false claims. App. 42-43. Where, as here, the government's agents, including the Medicare carriers and HCFA (now known as the Center for Medicare & Medicaid Services), contemporaneously interpreted the relevant regulations consistently with the defendants' own interpretation and have advised the defendants that their billing practices are proper, *see* App. 393-403, no relator should be permitted to claim a "knowing" violation of the billing regulations.

A. The Eighth Circuit's Ruling Impermissibly Allows Trial On Alleged Violations Of Unwritten Rules

The Eighth Circuit erred in holding that a fact issue exists regarding whether the defendants submitted false claims for violating Medicare criteria found nowhere in the payment regulations. By definition, defendants can be liable under the FCA only if their conduct violates some legal requirement – in other words, if they submitted a false claim. *See* 31 U.S.C. § 3729(a)(i).[9] Yet here, the Eighth Circuit entirely ignored the first essential element of an FCA claim – requiring the relator to provide evidence that the defendants made false claims for payment to the government.

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[9] A false claim is a necessary but not sufficient condition for liability under the FCA. As discussed below, the relator must also show the requisite intent.

The Eighth Circuit declined to analyze whether the relevant Medicare regulations clearly prohibited the defendants' alleged conduct, and instead subsumed the element of falsity within its discussion of intent. App. 38-45. The Eighth Circuit's refusal to consider falsity as a separate yet required element under the FCA ignores clear statutory requirements and is contrary to decisions in other circuits. *See* 31 U.S.C. § 3729(a)(i); *United States ex rel. Mikes v. Straus*, 274 F.3d 687, 696 (2d Cir. 2001); *United States ex rel. Oliver v. Parsons Co.*, 195 F.3d 457, 463 (9th Cir. 1999).

The far-reaching impact of the Eighth Circuit's decision is illustrated by the relator's assertion of phantom regulatory requirements. MANA based two claims against the anesthiologist defendants on alleged billing requirements found nowhere in the Medicare regulations. First, MANA alleged a requirement that anesthesiologists stay constantly in the operating room in order to bill Medicare for personally performed cases. Second, MANA alleged anesthesiologists must return to the operating room at the end of the surgical procedure in order to bill Medicare in all cases, whether personally performed or concurrent.

With regard to the alleged requirement of constant physical presence in the operating room, the regulation relevant at the time read in part as follows:

> (c) Physician personally performs the anesthesia procedure . . .
>
> (2) HCFA considers an anesthesia procedure to be personally performed by a physician if it meets one of the following circumstances: . . .
>
> (ii) The physician is *continuously involved* in a single case involving a certified registered nurse anesthetist (CRNA). . . .

App. 151-153 (42 C.F.R. § 414.46) (emphasis added). This regulation does not require that an anesthesiologist stay in the operating room throughout the case. The regulation states only that the physician must be "continuously involved" with the patient, a phrase which is undefined in the regulations. MANA's allegation that the defendants left the operating room – without more – cannot meet the "falsity" requirement under the FCA because the regulation does not require continuous physical presence in the operating room; it requires the anesthesiologist to remain "continuously involved."

Moreover, the defendants' understanding of the phrase "continuously involved" is not an isolated interpretation unique to them. Using the Freedom of Information Act, defendants' expert, a healthcare consultant, investigated interpretations of anesthesia billing regulations nationwide. *See* App. 404. The expert learned that Medicare carriers across the country interpreted Medicare's anesthesia billing regulations as the Minnesota Medicare carriers and defendants did. App. 418-421. This unrefuted evidence, together with the government's guidance described below in Part III.B., leaves no question that, as a matter of law, MANA cannot demonstrate that the defendants submitted false claims in personally performed cases.

With regard to MANA's allegations that anesthesiologists must be present at the conclusion of a surgical procedure, the relevant Medicare regulation reads in part as follows:

> (a) Services furnished directly or concurrently. The carrier will reimburse a physician for anesthesiology services furnished to patients . . . only if . . .
>
> (1) For each patient, the physician – . . .

> (iii) *Personally participates in* the most demanding procedures in the anesthesia plan, including induction and *emergence*. . . .

(42 C.F.R. § 405.552) (1991) (emphasis added). App. 157.

Without examining whether the regulation defines personal participation in emergence, the Eighth Circuit held that a fact issue exists regarding whether defendants submitted false bills to Medicare because they did not return to the operating room at the end of a case. App. 46-47. This holding, like the holding based on the alleged requirement to stay in the room, impermissibly separates the FCA's falsity requirement from any regulatory basis.

Nowhere in the regulations is emergence defined. MANA presented no evidence supported by medical experts of a medical definition of emergence, other than the standard one summarized by defendants' medical experts and adhered to by the defendants:

> [E]mergence is defined as the process of recovering from anesthesia. . . . An anesthesiologist can participate in emergence by checking on the patient in the recovery room and being available at other times in the emergence continuum.

App. 424-425; App. 462. Anesthesiologists' claims cannot be false when they followed this well-established medical definition of emergence in the absence of any contrary regulatory definition. *Cf. Corning Glass Works v. Brennan*, 417 U.S. 188, 201 (1974) ("[W]here Congress has used technical words or terms of art, it [is] proper to explain them by reference to the art or science to which they [are] appropriate.") (internal quotation omitted). Permitting MANA to proceed with claims without a regulatory basis demonstrates the real potential for draconian overreaching under the FCA. Without rectification by this Court, the

Eighth Circuit's decision permits further improper incursions into the provision of health care in this country.

B. The Circuits Are Split On Whether Reliance On Government Advice Is An Absolute Defense To FCA Liability

The Eighth Circuit improperly found a fact question relating to defendants' intent when it stated that differing interpretations of the Medicare regulations at issue raised "a question of fact as to [defendants'] state of mind." App. 40. The Eighth Circuit ignored the intent of Congress and significant contrary authority from other circuits in holding that, despite defendants' reliance on government guidance that they were complying with federal anesthesia billing regulations, defendants could have knowingly submitted false claims.

The FCA defines "knowing" or "knowingly" as "having actual knowledge of the information, or acting in either deliberate indifference to or reckless disregard for the information's truth or falsity." 31 U.S.C. § 3729(b). Congress amended the FCA in 1986 to include this definition of scienter to make "firm . . . its intention that the Act not punish honest mistakes or incorrect claims submitted from mere negligence." S. Rep. No. 99-345, at 7 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5272. Scienter is "the knowing presentation of what is known to be false." *United States ex rel. Hochman v. Nackman*, 145 F.3d 1069, 1073 (9th Cir. 1998) (citing *United States ex rel. Hagood v. Sonoma County Water Agency*, 929 F.2d 1416, 1421 (9th Cir. 1991) ("*Hagood I*")). The phrase "'known to be false' does not mean 'scientifically untrue;' it means a 'lie.'" *United States ex rel. Anderson v. Northern Telecom, Inc.*, 52 F.3d 810, 815-16 (9th Cir. 1995). The Eighth Circuit's decision in

this case abandons this definition of scienter and Congress's intent to preclude liability for innocently undertaken conduct.

Other circuits have held that where the issue of knowing submission of false claims turns on the interpretation of a federal regulation, contract, or statute, and defendants rely on the government's guidance, there can be no "inference that any party involved . . . knew" that its claims for payment were improper. *Hindo v. University of Health Sciences*, 65 F.3d 608, 613-14 (7th Cir. 1995) (affirming grant of directed verdict where defendant relied upon agency's expression of optimism that funding for claim would be available). *See also Hochman*, 145 F.3d at 1076 (defendants do not knowingly submit false claims if they believe their conduct was authorized by regulation or statute; affirming summary judgment); *United States ex rel. Hagood v. Sonoma County Water Agency*, 81 F.3d 1465, 1479 (9th Cir. 1996) ("*Hagood II*") (affirming summary judgment that defendant did not violate the FCA because it relied on the government and at most "took advantage of a disputed legal issue").

Several circuits have further held that a genuine or good faith belief that one's conduct is proper precludes a finding of the requisite intent necessary for FCA liability. *Mikes*, 274 F.3d at 703-04 (Second Circuit held defendants did not "as a matter of law" submit false claims when they had a good faith belief that services were of medical value); *Oliver*, 195 F.3d at 464 (Ninth Circuit held good faith nature of defendant's actions "forecloses the possibility that the scienter requirement is met"). *Cf. United States v. Levin*, 973 F.2d 463, 470 (6th Cir. 1992) (FCA indictment dismissed because HCFA letters endorsing

conduct of defendants made intent finding impossible as a matter of law).

The Medicare billing rules for anesthesia providers are among the most complex of Medicare's medical specialty regulations. App. 337. The notion that an inference of bad intent can be drawn from the mere existence of competing interpretations of undefined terms in complex regulations defies any reasonable definition of scienter. The Eighth Circuit concluded that "the defendants were on notice of the *possibility*" that the phrase "continuously involved" in 42 C.F.R. § 414.46(c)(2)(ii) required an anesthesiologist's constant physical presence in the operating room in order to bill Medicare for a personally performed case. App. 40 (emphasis added). The Eighth Circuit's conclusion ignored that the defendants sought, received and relied on advice from their Medicare carriers that the phrase "continuously involved" did *not* require an anesthesiologist's constant physical presence in the operating room. App. 393-400; 480. Similarly, the hospital defendants followed Medicare carrier instructions in billing CRNA services on medical necessity cases using the lower medically directed rate. App. 333-335; 383-384; 468-478. No doctor or hospital who relies on government guidance should be subject to claims of knowingly submitting false claims.

In the face of the government's knowledge of, and guidance consistent with, defendants' conduct, other circuits have found that a relator could not show the requisite intent for FCA liability. *See United States ex rel. Durcholz v. FKW Inc.*, 189 F.3d 542, 545 (7th Cir. 1999) (government knowledge and approval of defendants' conduct negates finding of requisite FCA intent); *United States ex rel. Butler v. Hughes Helicopters, Inc.*, 71 F.3d

321, 329 (9th Cir. 1995) (Army's knowledge of change in testing procedures negates finding that defendants knowingly submitted false claims).

The record leaves no question that the defendants had a good faith belief that their conduct fell within the meaning of the relevant regulations. They inquired of the government, putting the government on notice of their conduct, and they followed their Medicare carriers' advice. No bills to the government under these circumstances could amount to a lie or be the result of reckless conduct. *See Wang v. FMC Corporation*, 975 F.2d 1412, 1421 (9th Cir. 1992).

By allowing MANA's claim to proceed, the Eighth Circuit improperly extended the FCA beyond perpetrators of fraud to reach all those health care providers who struggle in good faith with the often nebulous pronouncements of Medicare officials. As a result, doctors and hospitals who acted in good faith face trial and potentially ruinous FCA fiens and penalties, a result Congress plainly did not intend.

CONCLUSION

For the reasons set forth above, petitioners Allina Health System, et al., respectfully request that this Court grant the Petition for Writ of Certiorari and provide such other relief as may be appropriate under the circumstances.

Dated: June 24, 2002

Respectfully submitted,

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United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 99-2356

Minnesota Association of Nurse Anesthetists, United States of America, ex rel.

Plaintiff-Appellant,

v.

Allina Health System Corp.; Unity Hospital; Mercy Hospital; Mark Sperry, M.D.; Gary Baggenstoss, M.D.; John Murphy; David Cumming, M.D.; John Rydberg, M.D.; Midwest Anesthesiologists, P.A.; Metropolitan Anesthesia Network; Health Billing Systems, Inc.; Allen Tank; Thelma M. Albay, M.D.; Minda Castillejos, M.D.; Teri Heil, M.D.; Sang Hong, M.D.; Ted Janossy, M.D.; Raymond Kloepper, II, M.D.; John Magdsick, M.D.; Thomas Maggs, M.D.; Thomas Polta, M.D.; John Roseberg, M.D.; Jai Suh; Jeffrey Yue, M.D.; Craig Johnson, M.D.; St. Cloud Hospital; Anesthesia Associates, of St. Cloud Ltd.; Gary A. Boeke, M.D.; Philip F. Boyle, M.D.; L. Michael Espeland, M.D.; Alan D. Espelien, M.D.; Paul J. Halverson, M.D.;

Appeal from the United States District Court for the District of Minnesota.

Lanse C. Lang, M.D.; A. Wade McMillan, M.D.; William H. Rice, M.D.; Allan Reitz, M.D.; Annette E. Zwick, M.D.; Anesthesiology, P.A.; Does, I through XX; Abbott Northwestern Hospital, Inc., Sued as Abbott Northwestern Hospital; Northwest Anesthesia, P.A.; Bryce Beverlin, M.D.; Richard Blomberg, M.D.; Jean Boening, M.D.; Mitchell Burke, M.D.; Rajarao Dwarakanath, M.D.; Richard Engwall, M.D.; James Gayes, M.D.; Luis Giron, M.D.; Nancy Groves, M.D.; Jonathan Gudman, M.D.; Richard W. Johnson, M.D.; John C. Lillehei, M.D.; Robert McKlveen, M.D.; Judith Meisner, M.D.; Michael Menzel, M.D.; James Musich, M.D.; Mark Nissen, M.D.; Xavier Pereira, M.D.; David Plut, M.D.; Jeffrey Shaw, M.D.; Richard Skoog, M.D.; William Stauffer, M.D.; Ofelio Tiu, M.D.; Robert Tronnier, M.D.; John Wintermute, M.D.; Does, I through XX (other unknown defendants);

Defendants-Appellees.

United States of America,

Movant

United States of America,

Amicus on Behalf of
Appellant.

Submitted: December 11, 2000
Filed: January 17, 2002

Before McMILLIAN and JOHN R. GIBSON, Circuit Judges, and LAUGHREY,[1] District Judge.

JOHN R. GIBSON, Circuit Judge.

The Minnesota Association of Nurse Anesthetists brought this qui tam suit as relator for the United States, alleging that the defendant hospitals[2] and anesthesiologists[3] had knowingly made false claims on the United

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[1] The Honorable Nanette K. Laughrey, United States District Judge for the Western District of Missouri, sitting by designation.

[2] The defendant hospitals are Unity Hospital, Mercy Hospital, Abbott Northwestern Hospital, and St. Cloud Hospital. Also named as defendants are hospital employees John Murphy and Allina Health System Corp., which is an "integrated health care system." We will refer to all these defendants collectively as the hospitals.

[3] Anesthesiologists are physicians who specialize in anesthesia. The defendant anesthesiologists are Thelma M. Albay, Gary Baggenstoss, Minda Castillejos, David Cumming, Teri Heil, Sang Hong, Ted Janossy, Raymond Kloepper, II, John Magdsick, Thomas Maggs, Thomas Polta, John Roseberg, Jai Suh, Mark Sperry, Jeffrey Yue, John Rydberg, Gary A. Boeke, Philip F. Boyle, L. Michael Espeland, Alan D. Espelien, Paul J. Halverson, Craig Johnson, Lanse C. Lang, A. Wade McMillan, William H. Rice, Allan Reitz, Annette E. Zwick, Bryce Beverlin, Richard Blomberg, Jean Boening, Mitchell Burke, Rajarao Dwarakanath, Richard Engwall, James Gayes, Luis Giron, Nancy Groves, Jonathan Gudman, Richard Johnson, John Lillehei, Robert McKlveen, Judith Meisner, Michael Menzel, James Musich, Mark

(Continued on following page)

States government by mischaracterizing services they had provided to Medicare patients. The Association pleaded that the defendants violated the False Claims Act, 31 U.S.C. § 3729 (1994), by overcharging the government for their services, and that they had conspired among each other to do so. The district court entered summary judgment for the defendants, holding that the Association's own earlier, public disclosure of the information on which this suit is based precluded subject-matter jurisdiction of this suit. The court also held that the Association lacked standing to bring this suit as relator because it had not shown that the mischaracterizations of the services resulted in pecuniary injury to the government. In addition to the jurisdictional and standing rulings, the court also made three holdings on the merits of the Association's case: that there was no showing of intent to defraud the government because the defendants billed in accordance with the advice given them by the Medicare carriers; that the "overwhelming majority of the evidence on the record" established that the defendants did not mischaracterize the services they provided; and that the Association adduced no evidence of conspiracy. We reverse except as to the judgment on the conspiracy allegations, which we affirm.

Nissen, Xavier Pereira, David Plut, Jeffrey Shaw, Richard Skoog, William Stauffer, Ofelio Tiu, Robert Tronnier, and John Wintermute. The Association also joined several practice groups and persons and corporations associated with them: Midwest Anesthesiologists, P.A., Metropolitan Anesthesia Network, Health Billing Systems, Inc., Allen Tank, Anesthesia Associates of St. Cloud Ltd., Anesthesiology, P.A., Northwest Anesthesia, P.A. We will refer to all these defendants collectively as the anesthesiologists.

I.

This case alleges false claims for services rendered under Part B of the Medicare program. The Medicare program is administered by the Department of Health and Human Services through the Health Care Financing Administration, or HCFA. Medicare Part B is a federally subsidized medical insurance program that pays a portion of the insured's medical expenses. The United States reimburses the medical expenses through the HCFA, which, in turn, contracts with private insurance companies to administer and pay claims from the Medicare Trust Fund. *United States v. Mackby,* 261 F.3d 821, 824 (9th Cir. 2001).

The Association represents the certified nurse anesthetists of Minnesota. Nurse anesthetists are registered nurses who administer anesthesia, either alone or under the supervision of an anesthesiologist. The Association claims that the defendant anesthesiologists and hospitals presented false claims for payment by mischaracterizing anesthesia services rendered to Medicare patients from about 1989 to 1997. Four kinds of mischaracterizations are alleged: billing on a reasonable charge basis when the services the anesthesiologists provided did not meet the criteria for reasonable charge reimbursement; billing services as personally performed by the anesthesiologist when the services did not meet the criteria for personal performance; billing as if the anesthesiologist involved were directing fewer concurrent cases than he or she actually did direct; and certifying that it was medically necessary for both an anesthesiologist and anesthetist to personally perform cases that in fact an anesthetist alone personally performed. Understanding the significance of these alleged mischaracterizations requires some

understanding of the Medicare regulations as they existed at the various times in question. We will therefore briefly explain the nature of each allegation before considering the questions of jurisdiction and standing and the merits of the case.

A.

The first type of mischaracterization alleged is that anesthesiologists billed services for reasonable charge reimbursement when they did not render services eligible for such reimbursement. In the early 1980s Congress became concerned that hospital-based physicians were charging Medicare for work performed by hospital employees. S. Rep. No. 97-494, at 22 (1982), *reprinted in* 1982 U.S.C.C.A.N. 781, 797-98. To stop this, Congress directed the Department of Health and Human Services to adopt regulations governing Medicare payments to physicians working in hospitals. Tax Equity and Fiscal Responsibility Act of 1982, Pub.L. No. 97-248, Title I, § 108, 96 Stat. 324, 337 (codified as amended at 42 U.S.C. § 1395xx(a)(1) (1994)). The regulations were to establish criteria for distinguishing between services rendered by a physician to an individual patient, which could be reimbursed on a reasonable charge basis, and services rendered to the provider or to the provider's patient population as a whole, which would be reimbursed on a reasonable cost basis. *Id.* Accordingly, the Department adopted regulations in 1983 outlining when physicians providing anesthesia services would be reimbursed on a reasonable charge basis. Conditions for payment of charges: Anesthesiology services, 48 Fed. Reg. 8902, 8926-28 (March 2, 1983). A physician could be reimbursed for anesthesiology services in a hospital on a reasonable charge basis if:

(1) For each patient, the physician

(i) Perform[ed] a pre-anesthetic examination and evaluation;

(ii) Prescrib[ed] the anesthesia plan;

(iii) Personally participat[ed] in the most demanding procedures in the anesthesia plan, including induction and emergence;

(iv) Ensure[d] that any procedures in the anesthesia plan that he or she d[id] not perform [were performed] by a qualified individual;

(v) Monitor[ed] the course of anesthesia administration at frequent intervals;

(vi) Remain[ed] physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provide[d] indicated postanesthesia care.

(2) The physician either perform[ed] the procedure directly, without the assistance of an anesthetist, or direct[ed] no more than four anesthesia procedures concurrently and [did] not perform any other services while he or she [was] directing those concurrent procedures.

42 C.F.R. § 405.552(a) (1983).

If the physician's services did not meet the criteria outlined above, then they were reimbursable only on a reasonable cost basis, as physician services to the provider. 42 C.F.R. § 405.552(b) (1983); 48 Fed. Reg. at 8927.

In its complaint in this case, the Association claimed that the anesthesiologists billed on a reasonable charge basis when they had not met the criteria for reasonable charge reimbursement and that the hospitals actively aided the anesthesiologists in the false billing. Specifically, the Association alleged that anesthesiologists at Unity, Mercy, and North Memorial hospitals commonly billed for medical direction of cases in which they never entered the operating room and of cases in which they were not present at the patient's emergence from anesthesia. At Abbott Northwestern and St. Cloud hospitals, the Association alleged that, while the anesthesiologists were usually present at emergence, they sometimes billed on a reasonable charge basis even though they were unavailable for emergencies (as shown by their failure to answer pages) and were absent at emergence.

B.

Second, the Association alleged that the anesthesiologists billed for personally performing cases when they did not meet the criteria for personal performance of the case.

Effective in 1992, HCFA adopted a three-tier system of payment for anesthesiologists providing anesthesia. 56 Fed. Reg. 59502, 59628 (Nov. 25, 1991) (codified at 42 C.F.R. § 414.46(c) (1992)). Under that system, Medicare would pay the highest rate when the anesthesiologist either personally performed the entire anesthesia case or was "continuously involved" in only one case in which an anesthetist was also involved. When an anesthesiologist billed a case as personally performed, the anesthetist involved would not be entitled to any Medicare reimbursement, unless there were special conditions requiring

attendance of both an anesthesiologist and an anesthetist at once. Sec. 414.46(c)(2). On the second tier, for medically directing two to four concurrent cases, the anesthesiologist would receive a lower rate, which in turn was diminished (during part of the relevant time) by a set percentage for each additional concurrent case. 42 C.F.R. § 414.46(d). At the third tier, the lowest rate was paid for supervision of more than four concurrent cases. 42 C.F.R. § 414.46(e).

The Association alleged that the anesthesiologists billed with the highest-rate "AA" modifier, designating that they had performed cases personally, when they were not continuously present during the case and in fact were simultaneously engaged in other activities, including medical direction of concurrent cases.

The anesthesiologists contend that when an anesthesiologist and anesthetist were both involved in one case, with no concurrent procedures, an anesthesiologist was entitled to designate a case as personally performed so long as he or she met the criteria for medical direction of the anesthetist. Specifically, the anesthesiologists contend that personal performance of a single case involving an anesthetist did not require the anesthesiologist's continuous presence in the operating room, as long as the anesthesiologist was present in the operating suite. Thus, according to the anesthesiologists, when they had only one case at a time, they were entitled to be paid at the higher, "personal performance" rate even though they were performing the same duties otherwise compensated at the lower, "medical direction" rate. The corollary of this theory is that anesthetists would be paid for their work on a case if the anesthesiologist happened to be performing a concurrent case, but would not be entitled to Medicare reimbursement for performing the very same

duties in a case in which the anesthesiologist had no concurrent case.

The Association, on the other hand, contends that in order to be paid the higher rate for personally performing a case, an anesthesiologist had to be more closely involved than was necessary to satisfy the medical direction criteria of section 405.552, and in fact, had to be continuously present with the patient.

C.

The Association also alleged that the anesthesiologists misrepresented the number of cases they were performing concurrently. As we said in section B, the 1992 regulations reduced an anesthesiologist's medical direction fee per case as the number of cases he or she directed increased (up to the maximum of four). 42 C.F.R. § 414.46(d) (1992). This was apparently a short-lived policy, which was changed as of January 1, 1994 to a flat rate per case, no matter whether the anesthesiologist was directing two, three or four concurrent procedures. Omnibus Reconciliation Act of 1993, Pub.L. No. 103-66, § 13516, 107 Stat. 312, 583-84 (1993). The Association alleged that while the 1992 regulations were in force, the anesthesiologists regularly understated the number of concurrent cases they were directing simultaneously in order to get a bigger payment from Medicare than they were entitled to.

D.

Finally, the Association alleges that the hospitals represented in many cases that it was necessary for both an anesthesiologist and anesthetist to personally perform

the case, whereas only the anesthetist actually satisfied the criteria for personal performance.

Congress decided in 1986 that anesthetists' services should be reimbursable under Part B of Medicare on a reasonable charge basis, starting on January 1, 1989. Omnibus Reconciliation Act of 1986, Pub.L. No. 99-509, § 9320, 100 Stat. 1874, 2013-16 (1986). Before this, Medicare did not pay for anesthetists' anesthesia services on a reasonable charge basis. *See* 48 Fed. Reg. at 8927. Even after the law was changed to allow direct reimbursement for anesthetists' services, when an anesthesiologist was involved with only one case at a time and an anesthetist worked on that case as well, Medicare would not ordinarily pay for the anesthetist's services because it was considered inefficient to have both an anesthesiologist and an anesthetist wholly engaged in one case. 57 Fed. Reg. 33878, 33887 (July 31, 1992) ("[W]e are concerned that recognizing medical direction in a single anesthesia procedure would encourage inefficiencies in anesthesia practice arrangements. Our policies should not encourage the involvement of both practitioners in a single anesthesia procedure if either practitioner could appropriately furnish the service alone."). However, if there was some unusual medical necessity requiring the attendance of both anesthesiologist and anesthetist on the same case, Medicare would then pay for both at 100% of their usual personal performance rate. 42 C.F.R. § 414.46(c)(3) (1992); *see* HCFA Transmittal No. B-98-2 (1998). Later, the regulation was amended to allow both anesthesiologist and anesthetist to bill for these "one-on-one" cases even without special medical necessity, but the total payout was to be limited to the amount that would have been paid to the anesthesiologist for doing the case alone. 60 Fed. Reg.

38400, 38416 (July 26, 1995) (proposing payment scheme to begin in 1998).

The Association alleges that in order to collect payment for both an anesthesiologist and an anesthetist performing a single case, the hospitals sometimes certified that there was a medical necessity for both to attend, whereas in fact the anesthesiologist did not assist throughout the case, demonstrating that no necessity existed.

II.

On December 28, 1994, the Association brought this suit on behalf of the United States alleging violation of the False Claims Act, 31 U.S.C. §§ 3729(a)(1) and (2) and (7), conspiracy to violate the Act, and violation of the hospitals' Medicare provider agreements in connection with their anesthesia billing practices. The United States declined to intervene.

At the threshold, we must decide whether we have subject-matter jurisdiction over this case. On November 8, 1994, some seven weeks before filing this case, the Association and several individual anesthetists sued many of the same defendants alleging various federal antitrust and state law violations, again in connection with their anesthesia billing practices. The antitrust complaint alleged:

> [T]he defendant anesthesiology groups and their co-conspirators have engaged in a wide-spread practice of fraudulent billing of anesthesia services in violation of . . . Federal statutes, including § 1128(a)(1)(A). Such violations include, but are not limited to, billing for services that they did not render, billing for operations at which

> they were not present and inaccurately designating operations as one-on-one for Medicare purposes.

The allegations in the Association's antitrust case were immediately reported in the local newspapers in St. Paul and St. Cloud on November 10 and 11. The Association also provided a copy of the antitrust case to the United States government. Only after this publicity did the Association file this False Claims Act case, under seal, as provided by statute.

The district court held that the disclosure of allegations of fraud in the Association's antitrust suit and in newspaper articles about the antitrust suit precluded subject-matter jurisdiction over this qui tam case because of a special jurisdictional limitation in the False Claims Act disallowing suits based on publicly disclosed information, 31 U.S.C. § 3730(e)(4)(1994). In addition to the disclosures the district court cited, the defendants contend that instances of one type of claim alleged by the Association, improper billing of one-on-one cases, were disclosed in the course of an administrative audit before the Association had assembled its allegations, likewise depriving the district court of subject-matter jurisdiction over that claim.

The level of our review of a district court's ruling on subject-matter jurisdiction depends on whether the district court based its determination on the complaint, on undisputed facts outside the complaint, or on findings of fact. *See Osborn v. United States,* 918 F.2d 724, 729-30 (8th Cir. 1990). In this case, the district court limited its jurisdictional inquiry to the complaint and undisputed facts, styling its order as a summary judgment. *See generally id.* at 729-30 (discussing distinction between subject-matter

jurisdiction determination under Fed.R.Civ.P. 12(b)(1) and summary judgment). Therefore, we exercise de novo review, limited to "determining whether the district court's application of the law is correct and, if the decision is based on undisputed facts, whether those facts are indeed undisputed." *Id.* at 730 (quotations omitted).

The limitations on subject-matter jurisdiction over False Claims qui tam cases were enacted as part of the False Claims Amendments Act of 1986, Pub.L. No. 99-562, 100 Stat. 3153, 3157 (1986). The 1986 amendments were an avowed attempt to reinvigorate the False Claims Act after a 1943 amendment and judicial decisions interpreting the 1943 amendment had emasculated the 1863 law. Understanding the Congressional intent expressed in the 1986 amendments therefore requires a review of False Claims Act history.

The original False Claims Act was enacted in 1863 in order to strike back against the fraud of unscrupulous Civil War defense contractors. S.Rep. No. 99-345, at 8 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5273. The Act contained a qui tam provision allowing private persons to sue as relators representing the government's interests, and it rewarded relators who prevailed in their suits with a bounty of half the damages and forfeitures they recovered for the government.[4] *Id.* at 10. The large size of the relator's share, which came out of the government's ultimate recovery, had an obvious potential to put the relator and the government at odds with each other.

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[4] Under the current statute the size of the bounty varies, but can be as high as thirty percent of the proceeds of the suit. 31 U.S.C. § 3730(d) (1994).

During World War II there were many qui tam cases against defense contractors, and in one notorious case, *United States ex rel. Marcus v. Hess,* 317 U.S. 537 (1943), the government contended that the relator had simply copied allegations from a criminal indictment already on file. The Supreme Court held that, even if the relator, Marcus, had simply taken allegations from a criminal indictment, the False Claims Act would nevertheless permit him to proceed as relator. *Id.* at 545. In reaction to *Hess,* Attorney General Francis Biddle asked Congress to repeal the qui tam provisions of the False Claims Act. S. Rep. No. 99-345, at 11. Congress refused to go so far, but it did amend the Act to provide that there would be no jurisdiction over qui tam suits "whenever it shall be made to appear that such suit was based upon evidence or information in the possession of the United States, or any agency, officer or employee thereof, at the time such suit was brought."[5] 31 U.S.C. § 232(C) (1946); S. Rep. No. 99-345, at 12. The provision was explained as an attempt to curtail parasitical suits in which the informer "rendered no service" to the government. 89 Cong. Rec. 10846 (1943). In *United States ex rel. Wisconsin v. Dean,* 729 F.2d 1100 (7th Cir. 1984), the State of Wisconsin brought a qui tam suit based on Medicaid fraud that it had already disclosed to the federal government. The Seventh Circuit, interpreting the 1943 amendment, held that even though the discovery of the fraud was entirely due to the State's investigation, qui tam jurisdiction was barred because the

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[5] This provision was interpreted to apply only in the event the government declined to take up prosecution of the case itself. S.Rep. No. 99-345, at 12.

federal government knew of the fraud before Wisconsin filed suit. *Id.* at 1104-07.

Within months of the *Dean* decision, the National Association of Attorneys General adopted a resolution urging Congress "to rectify the unfortunate result of the *Wisconsin v. Dean* decision." S. Rep. No. 99-345, at 13. Congress responded. Senate Bill 1562, which became the 1986 False Claims Amendments Act, was introduced shortly after and was "aimed at correcting restrictive [court] interpretations" of the False Claims Act which "tend to thwart the effectiveness of the statute."[6] *Id.* at 4, 13. The goals of the 1986 Amendments Act were (1) to encourage those with information about fraud against the government to bring it into the public domain; (2) to discourage parasitic qui tam actions by persons simply taking advantage of information already in the public domain; and (3) to assist and prod the government into taking action on information that it was being defrauded. *United States ex rel. Mistick PBT v. Hous. Auth.,* 186 F.3d 376, 401 (3d Cir. 1999) (Becker, C.J., dissenting) (citing S. Rep. No. 99-345, at 1-8, 23-24), *cert. denied,* 529 U.S. 1018 (2000).

The 1943 amendments could bar qui tam suits on the ground of information technically in the government's

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[6] In addition to recalibrating the provisions dealing with parasitical suits, the 1986 Amendments Act aimed to "encourage more private enforcement suits," S.Rep. No. 99-345, at 23-24, by various other measures, including increased monetary awards, a lower burden of proof, and a guaranteed role for the relator even when the government intervenes in the action. *United States ex rel. Stinson, Lyons, Gerlin & Bustamante, P.A. v. Prudential Ins. Co.,* 944 F.2d 1149, 1154 (3d Cir.1991).

possession, even if no one in the government knew about the information. 132 Cong. Rec. 22340 (1986) (remarks of Rep. Bedell). The supporters of the 1986 Amendments Act believed that this prevented relators from bringing suits in situations in which their participation was needed and in which the fraud would not be prosecuted without their intervention. In an apparent attempt to correct this shortcoming of the 1943 version of the Act, Congress switched from barring suit on the ground of government possession of information before the relator filed suit to barring suit on the ground of public disclosure of such information. *See id.* (referring to House bill). Congress evidently assumed that if information was publicly disclosed, the government was likely to discover it on its own, without the need for a qui tam relator. *See United States ex rel. Stinson, Lyons, Gerlin & Bustamante, P.A. v. Prudential Ins. Co.*, 944 F.2d 1149, 1169 (3d Cir. 1991) (Scirica, J., dissenting).

The 1986 Act also added an important exception to the jurisdictional bar for relators who are "an original source of such information." The relevant section is 31 U.S.C. § 3730(e)(4):

> (A) No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

> (B) For purposes of this paragraph, "original source" means an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under this section which is based on the information.

Section 3730(e)(4) is crucial to resolving the jurisdictional issue in the present case. Applying the section requires us to answer three questions: (1) Have allegations made by the relator been "publicly disclosed" before the qui tam suit was brought? (2) If so, is the qui tam suit "based upon" the public disclosure? and (3) If so, was the relator an "original source" of the information on which the allegations were based? *See United States v. Bank of Farmington,* 166 F.3d 853, 859 (7th Cir. 1999) (applying tripartite test). Jurisdiction exists only if the answer to one of the first two questions is "no" or the answer to the third question is "yes." The original source inquiry, in turn, has three parts; the relator's knowledge of the information must be (1) direct and (2) independent, and (3) the relator must have voluntarily provided the information to the Government before filing suit.

The Association contends that the goals of the 1986 Amendments, including the intent to revise the law after the unsatisfactory result in *Dean*, would be thwarted by interpreting the 1986 Amendments Act to bar suits by relators who caused the public disclosure of the fraud. However, the various components of the statute have been interpreted by the courts in such a way that, when the pieces are put together, the result is sometimes to bar such actions. *See, e.g., United States ex rel. Dhawan v. New York Med. Coll.,* 252 F.3d 118, 121-22 (2d Cir. 2001) (relator who

disclosed information in state court suit was thereby barred); *United States ex rel. Hafter v. Spectrum Emergency Care, Inc.*, 190 F.3d 1156, 1163 (10th Cir. 1999) (relator whose information was "impetus" for investigation was barred by disclosure of results of investigation); *United States ex rel. Mistick PBT*, 186 F.3d at 389 (relator whose FOIA request brought fraud to light was barred because the government's response to the request was public disclosure); *United States ex rel. Jones v. Horizon Healthcare Corp.*, 160 F.3d 326, 335 (6th Cir. 1998) (relator's state lawsuit disclosed claims and therefore barred federal qui tam suit); *United States ex rel. Devlin v. California*, 84 F.3d 358, 360, 363 (9th Cir. 1996) (relator who fed allegations to newspaper barred because resulting article disclosed fraud); *United States ex rel. Kreindler & Kreindler v. United Tech. Corp.*, 985 F.2d 1148, 1159 (2d Cir. 1993) (relator who caused information to be revealed in the course of discovery in a lawsuit barred thereby). The Association cites a letter by the sponsors of the 1986 Amendments Act reviewing the career of the public disclosure bar in the courts: "Certain courts have exploded this limited bar in ways that mock the very purpose and intent of the 1986 Amendments." Letter from Rep. Howard L. Berman and Sen. Charles E. Grassley to Janet Reno, 145 Cong. Rec. E1540, 1546 (July 14, 1999).[7]

Our task, of course, is to effectuate Congress's intent, and we must interpret the three subsidiary components of

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[7] While legislators' comments regarding the intent of an earlier Congress are entitled to no special weight, *Central Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A.*, 511 U.S. 164, 185-86, 114 S.Ct. 1439, 128 L.Ed.2d 119 (1994), their legal analysis is entitled to the same consideration as any other commentator's.

section 3730(e)(4) with a view to how they contribute to the effect of the statute as a whole.

> [A] section of a statute should not be read in isolation from the context of the whole Act, and . . . in fulfilling our responsibility in interpreting legislation, we must not be guided by a single sentence or member of a sentence, but [should] look to the provisions of the whole law, and to its object and policy.

State Highway Comm'n v. Volpe, 479 F.2d 1099, 1111-12 (8th Cir. 1973) (citations omitted).

A.

The first question, whether the allegations have been publicly disclosed, must be answered "yes." The Association essentially concedes that the antitrust suit and the resulting newspaper articles amounted to public disclosure, as the district court held.

However, on appeal the defendants further contend that the Association's allegations were also publicly disclosed through a 1991 audit performed for Medicare by The Travelers, which, as an administrative audit, would qualify as one of the types of public disclosure that could trigger the jurisdictional bar. In the audit, Travelers notified Mercy Medical Center that it had been billing for anesthetists' services in cases in which the anesthetist and anesthesiologist were both working on the same case and no other concurrent cases, known as one-on-one cases.

Review of the Association's claims indicates that this is not one of the practices the Association alleges is fraudulent. The Association contends that some of the

alleged fraudulent practices arose as a response to the 1991 audit, when the hospitals realized they could no longer bill for both the anesthesiologist and an anesthetist's service in routine one-on-one situations, and so began falsely certifying that such cases required the involvement of both an anesthesiologist and an anesthetist. Therefore, the 1991 audit was not a public disclosure of this allegation.

The Association also contends that the anesthesiologists billed for personally performing cases in which they were not "continuously involved" with the patient or case. In contrast, the audit letter does not say that the anesthesiologists were not performing the cases, but instead concludes that they *were* performing them, which meant that the hospital could not bill for the anesthetist's involvement in the same case. Therefore, the audit did not publicly disclose this allegation of fraud, either. The defendants contend that the transactions pointed out in the audit are some of the same transactions on which the Association now bases its claims. The audit may have revealed the fact that the defendants represented that the anesthesiologists performed these cases, but the audit did not state that the anesthesiologists had not in fact done so. In order to bar jurisdiction, a public disclosure must reveal both the true state of facts and that the defendant represented the facts to be something other than what they were. *United States ex rel. Rabushka v. Crane Co.,* 40 F.3d 1509, 1514 (8th Cir. 1994). The audit did not reveal what the Association now contends was the true state of the facts, i.e., that the anesthesiologists were not performing the cases they billed for. Therefore, the audit was not a public disclosure that could bar jurisdiction over the Association's claims.

B.

The second question under section 3730(e)(4) is whether the allegations in the qui tam case were "based upon" the public disclosure. This requires us to address the meaning of those words, a question which has split the federal circuits, but which our court has not yet explicitly addressed.

The minority view, shared only by the Fourth Circuit and one panel of the Seventh Circuit (in schism with another panel),[8] is that "based upon" should be given its ordinary meaning of "derived from," so that the qui tam allegation must have resulted from the disclosure in order to bar jurisdiction. *United States ex rel. Siller v. Becton Dickinson & Co.,* 21 F.3d 1339, 1348 (4th Cir. 1994); *United States v. Bank of Farmington,* 166 F.3d 853, 863 (7th Cir. 1999). The minority bases its reading on a "straightforward textual exegesis" of the phrase "based upon," *Siller,* 21 F.3d at 1348, as well as the policy consideration that a suit not derived from the public disclosure is not "parasitic," and so is not the kind of suit the 1986 Amendments Act was meant to prevent, *Bank of Farmington,* 166 F.3d at 863.

The majority view is that a qui tam suit is "based upon" a public disclosure whenever the allegations in the suit and in the disclosure are the same, "regardless of

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[8] The split of authority is not quite as lopsided as it seems, for the issue has provoked spirited disagreements in some circuits that have adopted the majority view. *See, e.g., United States ex rel. Mistick PBT v. Housing Auth.,* 186 F.3d 376, 394-402 (3d Cir.1999) (Becker, C.J., dissenting), *cert. denied,* 529 U.S. 1018 (2000); *United States ex rel. Jones v. Horizon Healthcare Corp.,* 160 F.3d 326, 336 (6th Cir.1998) (Gilman, J., concurring in result).

where the relator obtained his information." *United States ex rel. Doe v. John Doe Corp.*, 960 F.2d 318, 324 (2d Cir. 1992). *Accord United States ex rel. Findley v. FPC-Boron Employees' Club*, 105 F.3d 675, 682-85 (D.C. Cir. 1997); *United States ex rel. Mistick PBT v. Housing Auth.*, 186 F.3d 376, 385-88 (3d Cir. 1999) (qui tam suit based upon disclosure if the disclosure "sets out" allegations or all essential elements of qui tam claim), *cert. denied*, 529 U.S. 1018 (2000); *United States ex rel. McKenzie v. BellSouth Telecom., Inc.*, 123 F.3d 935, 940 (6th Cir. 1997) ("based upon" public disclosure means "supported by" disclosure); *United States ex rel. Lamers v. City of Green Bay*, 168 F.3d 1013, 1017 (7th Cir. 1999) (relevant facts disclosed in media after relator filed administrative complaint and before relator filed qui tam suit; therefore qui tam jurisdiction barred unless relator an original source); *United States ex rel. Biddle v. Board of Trustees of the Leland Stanford, Jr., Univ.*, 161 F.3d 533, 536-40 (9th Cir. 1998); *United States ex rel. Precision Co. v. Koch Indus., Inc.*, 971 F.2d 548, 552-53 (10th Cir. 1992) ("As a matter of common usage, the phrase 'based upon' is properly understood to mean 'supported by.'"); *Cooper v. Blue Cross and Blue Shield*, 19 F.3d 562, 567 (11th Cir. 1994) (per curiam) ("based upon" means "supported by").

The majority view has a powerful argument to commend it: if a suit is only based upon a public disclosure if it results from the disclosure, as the minority interpretation would have it, then the statute's additional provision allowing suit if the relator is "an original source" of the underlying information is of no effect, because no one could be an original source if his knowledge was derived

from public disclosure.[9] More specifically, a relator's knowledge could not be "independent" of the public disclosure, § 3730(e)(4)(B), if it was derived from the public disclosure. The majority of courts have considered it inconceivable that Congress would have drafted the statute so poorly as to have included a provision that could never have any effect.

There are two considerable objections to this majority rule. First, its reading distorts the plain meaning of the words "based upon the public disclosure," since if the qui tam allegations are not derived from the public disclosure itself, they are not based upon the *public disclosure,* but rather on the *facts* which have been publicly disclosed. Elsewhere in the statute, Congress used the phrase "based

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[9] Chief Judge Becker of the Third Circuit has proposed a reading by which Congress could have used "based upon" in its ordinary sense of "derived from" and still have denoted something different by the "original source" provision. *Mistick PBT,* 186 F.3d at 399 ("[I]t is possible that a qui tam claim need not be derived entirely from public disclosures to fall under the 'based upon' jurisdictional bar, as long as *some* essential element of the qui tam claim is derived from public disclosures. . . . Under this view, a relator who is barred because he has derived some of his fraud information from a public disclosure may still bring the claim as an original source if he has direct and independent knowledge of some other essential element of the claim."). According to his interpretation, a suit derived *in part* from public disclosure may be allowed if it is also partly not derived from a public disclosure.

This interpretation is possible, but not plausible. It requires us to conclude that Congress used the "based upon" language and the "original source" language to refer to the same concept – whether a suit is derived from a public disclosure. Moreover, it would have been much more natural and straightforward for Congress to have said "*partly* based upon the public disclosure" and "original source of *part* of the information" if the distinction between partial derivation and sole derivation had been central to how Congress meant the statute to work.

on the facts underlying the pending action," 31 U.S.C. § 3730(b)(5), which suggests the drafters distinguished between basing a suit on facts and basing it on a disclosure of such facts. The majority's interpretation also distorts the words "based upon" by taking away the causal relation inherent in the phrase. As the Fourth Circuit remarked, "We are unfamiliar with *any* usage, let alone a common one or a dictionary definition, that suggests that 'based upon' can mean 'supported by.'" *Siller,* 21 F.3d at 1349. This objection may well be unanswerable. The Third Circuit, in adopting the majority rule, candidly admitted that the "in ordinary usage the phrase 'based upon' is not generally used to mean 'supported by,'" *Mistick PBT,* 186 F.3d at 386, but concluded that there was elsewhere evidence that the statute was not carefully drafted. *Id.* at 387. Evidently, the words "based upon" were simply not well chosen to express Congress's meaning.

The second objection to the majority view is that the policy justification sometimes given by courts in the majority, if taken to its logical conclusion, would return us to the rule of the *Dean* case, which Congress was specifically attempting to overrule by means of the 1986 Amendments Act. For instance, the District of Columbia Circuit justified its adoption of the majority rule as follows:

> [T]he blocking of freeloading relators who copy their complaints directly from public disclosures is not the FCA's only concern. From its inception, the *qui tam* provisions of the FCA were designed to inspire whistleblowers to come forward promptly with information concerning fraud so that the government can stop it and recover ill-gotten gains. Once the information is in the public domain, there is less need for a financial

> incentive to spur individuals into exposing frauds.

FPC-Boron Employees' Club, 105 F.3d at 685. By this reasoning, once the information is available to the government, the government has no need to pay a relator for disclosing it, even if the relator discovered the fraud in the first instance. Against this, the minority view reasons that by attempting to overrule the *Dean* case legislatively and especially by enacting the "original source" exception to the jurisdictional bar, Congress obviously rejected this one-shot view of its financial interests in favor of a fairness policy. Rather than biting the hand that fed it, Congress apparently chose to take a longer view, reasoning that its interests over time would be served by rewarding informants rather than confiscating their claims whenever it could do so.[10]

The minority objects that the majority's reading of "based upon" throws up a jurisdictional bar in some suits that are not parasitical, in the sense of being cribbed from the public disclosure, whereas the avowed goal underlying the 1986 Amendments Act was to eliminate parasitical suits. *See FPC-Boron Employees' Club,* 105 F.3d at 685 (acknowledging that "our interpretation of the jurisdictional

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[10] At the same time, Congress's view of what a relator deserves to recover is plainly affected by the utility of the information to the government, rather than merely whether the discovery was original or derivative. Thus, section 3730(b)(5) provides, "When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action." So, once a qui tam action is pending, no new relator can bring suit on the same fraud, no matter how he or she discovered it. Therefore, it is not inconsistent with Congress's scheme that some claimants who are not parasitic nevertheless do not get to be relators.

bar may on occasion prevent *qui tam* lawsuits that may not be truly 'parasitic' "). The minority view contends that by trying to rectify *Dean,* Congress showed a desire to treat relators fairly, which would be frustrated by kicking relators out of court when their claim was not parasitical, but was merely disclosed before the relator had filed suit.

In our view, however, these policy objections disappear if one considers the overall design of the public disclosure provision. Congress's fairness concern is not effectuated by each part of the statute read in isolation, but rather by the statute as a whole. The "based upon" clause serves the concern of utility, that is of paying only for useful information, and the "original source" exception serves the concern of fairness, that is of not biting the hand that fed the government the information. If the "based upon" clause threatens to kick relators out of court because the government does not need them, the "original source" exception reopens the courthouse door for certain deserving relators. Therefore, the majority view reaches the correct result, not because Congress cared nothing for fairness and everything for utility, but because it used two different provisions to strike a balance between these concerns.

Thus, the majority reading of section 3730(e)(4) is consistent with Congress's apparent policy. We also conclude that the majority view, though not free of strain, gives a more coherent meaning to the confusing language of the section than the minority view does. A final factor supporting the majority's reading is that it fits with the drift of our circuit precedent.

Our court has not expressly considered the meaning of the "based upon" clause, although Judge Magill has announced his support of the majority rule in a dissent.

United States ex rel. Rabushka v. Crane Co., 40 F.3d 1509, 1527-28 (8th Cir. 1994). However, in *United States ex rel. Barth v. Ridgedale Electric, Inc.*, 44 F.3d 699, 702 (8th Cir. 1995), we held that a suit was barred because of a public disclosure in newspaper articles that were not published until after one would-be relator had completed its investigation and reported the allegations to the County Attorney. From the chronology of these events, it is obvious that the allegations of the qui tam complaint in *Barth* were not derived from the newspaper articles. Nevertheless, *Barth* parsed the original source provisions, which would have been utterly unnecessary if the suit had not been "based upon" public disclosures, and concluded that the relators could not prosecute the suits because they were not original sources of the information. *Id.* at 704. Because the result in *Barth* would have been different if "based upon" meant "derived from," that case suggests that the issue has been resolved in this circuit, albeit implicitly, consistently with the majority rule.

Having concluded that the majority rule makes better sense of the 1986 Amendments Act and better effectuates the policy goals of that Act, we now explicitly endorse the majority view and hold that the allegations in this case were "based upon" the antitrust case and accompanying newspaper accounts.

C.

Finally, we come to the question of whether the Association was an "original source" of the information disclosed. If not, then there is no jurisdiction over this case. Since we know from the history of the False Claims Act that the original source provision was added in 1986 to

permit claims like the one in *Dean,* in which a claimant investigated the fraud and then revealed it to the government before filing suit, we would expect that the effect of the original source provision is to protect from the public disclosure bar those who first bring a claim to light. However, "original source" is defined in section 3730(e)(4)(B) in a way that does not distinguish between those who first bring a claim to light and others who later make the same discovery independently,[11] and it does not always protect those responsible for the initial disclosure of a fraud claim, *e.g., Barth,* 44 F.3d at 702-04.

Under section 3730(e)(4)(B), a claimant is deemed an original source if he or she (1) has "direct and independent knowledge of the information on which the allegations are based" and (2) has voluntarily provided the information to the "Government" before filing the qui tam suit.[12]

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[11] The Second and Ninth Circuits have held that only a person who caused the public disclosure can be an original source. *Wang v. FMC Corp.,* 975 F.2d 1412, 1418-20 (9th Cir. 1992); *United States ex rel. Dick v. Long Island Lighting Co.,* 912 F.2d 13, 16-18 (2d Cir. 1990). That rule would perhaps be an improvement in the operation of the original source provision, but it has no basis in the statutory language and we therefore decline to adopt it.

[12] The defendants argue that there is an additional requirement that an original source must be a natural person because section 3730(e)(4)(B) says: " 'original source' means an individual. . . . " But if examination of a statute shows "no plausible reason why Congress would have intended to provide for . . . special treatment of actions filed by natural persons and to have precluded entirely jurisdiction over comparable cases brought by corporate persons," *Clinton v. City of New York,* 524 U.S. 417, 429 (1998), the word "individual" does not limit the statute's scope to human beings. *Id.* Neither the 1986 Amendments Act nor a review of its background or legislative history suggests that Congress meant to exclude suits on the basis of whether the relator was

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We have determined that the words "direct" and "independent" were intended to express two ideas, rather than one. *Barth,* 44 F.3d at 703. We have interpreted "independent knowledge" to mean knowledge not derived from the public disclosure. *Id. But see United States ex rel. Fine v. Advanced Sciences, Inc.,* 99 F.3d 1000, 1006-07 (10th Cir. 1996) (independent means independent of anyone else – i.e., the same thing as direct). The independent knowledge requirement clearly serves the congressional goal of barring parasitic actions, but it is worth noting that it does not bar actions based on old news, in which the relator independently discovers information already known to the public. *See Fed. Recovery Servs., Inc. v. United States,* 72 F.3d 447, 452 (5th Cir. 1995) (this situation addressed in 31 U.S.C. § 3730(d)(1), which reduces size of relator's award). There is no doubt that the Association's knowledge was independent of the Association's antitrust case and the newspaper articles based on that case.

But did the Association also have direct knowledge? This term is more problematic. Courts have used various formulations, sometimes looking at the words without any reference to what Congress hoped to accomplish by using the term, and sometimes focusing on the policy of avoiding parasitism without paying much attention to the actual words Congress employed. The Third Circuit cited a dictionary definition of "direct" as "marked by absence of an intervening agency, instrumentality or influence: immediate." *Stinson, Lyons,* 944 F.2d at 1160 (quoting Webster's Third International Dictionary 640 (1976)). We

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a natural person, corporation, or association. We therefore reject this argument.

reiterated this definition in *Barth,* 44 F.3d at 703 (quoting *United States ex rel. Springfield Term. Ry. Co. v. Quinn,* 14 F.3d 645, 656 (D.C.Cir. 1994)). Also in *Barth* we quoted the Ninth Circuit's definition of direct knowledge as "unmediated by anything but [the plaintiff's] own labor," *id.* (quoting *Wang,* 975 F.2d at 1417), which reflects the congressional intent to avoid parasitical suits in which the plaintiff contributed nothing.

The district court held that the Association had no direct knowledge of the information because its knowledge came from its members. The court cited two cases in which corporations were formed after the information had been discovered and disclosed by people who became shareholders of the corporations; in these cases, the corporations were not original sources of the information. *Federal Recovery Servs.,* 72 F.3d at 451-52; *Precision Co.,* 971 F.2d at 554. These cases are easily distinguishable, because they involved a corporate plaintiff that did not exist at the time the information was discovered. No courts have held that corporations responsible for the discovery of information cannot have "direct knowledge" because they have to act through agents. In fact, corporate plaintiffs have been held to have direct knowledge making them an original source. In *Springfield Terminal Railway Co.,* 14 F.3d at 657, the District of Columbia Circuit held that a corporate relator had sufficiently direct knowledge of information to be an original source. *Accord United States ex rel Durcholz v. FKW Inc.,* 997 F. Supp. 1159, 1166 (S.D. Ind.1998). Moreover, in *Barth* one relator was a labor union; although we held that the union had no direct knowledge of the information because its representative did not have such knowledge, we did not suggest organizations can never be original sources. 44 F.3d at 703-04. There is no hint in the

history of the 1986 Amendments Act that Congress intended to disqualify organizational relators.[13] To the contrary, any such rule would have disqualified the State of Wisconsin from proceeding as relator in *Dean* and so would defeat one of the announced motivations behind the 1986 Amendments Act. Though organizations must, of course, act through agents, this does not render their knowledge parasitical or their agency "intervening" in the sense of interrupting the causal connection between the corporation's efforts and the knowledge. *See Black's Law Dictionary* 212 (7th ed. 1999) ("intervening cause" or "intervening agency" is "An event that comes between the initial event in a sequence and the end result, thereby altering the natural course of events that might have connected a wrongful act to an injury").

In further contrast to the corporate relators in *Precision Co.* and *Federal Recovery Services,* the Association is an unincorporated association. Unlike a corporation, a voluntary unincorporated association has no legal status separate from its members. *See St. Paul Typothetae v. St. Paul Bookbinders' Union,* 102 N.W. 725 (Minn.1905) ("Such [unincorporated] societies, in the absence of statutes recognizing them, have no legal entity distinct from that of their members."). By statute Minnesota altered the common law to permit persons associated under a common name to sue under that name, Minn.Stat. Ann. § 540.151 (2000), but this statute is only procedural. Unincorporated associations derive their rights from the rights of their

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[13] If Congress had harbored some hostility to organizational relators, it would have been odd to disqualify them only in the event that their claims were publicly disclosed before they filed suit, but that would be the effect of the interpretation defendants propose.

members. *See Federal Election Comm'n v. Colo. Republican Fed. Campaign Comm.*, 121 S.Ct. 2351, 2362 n.10 (2001) (First Amendment rights). Thus, associations can have standing to assert their members' rights in court, *see United Food & Commercial Workers Union Local 751 v. Brown Group, Inc.*, 517 U.S. 544, 551-53 (1996), whereas a corporation has no standing to assert rights belonging to its shareholders, *Waseca Co. Bank v. McKenna*, 21 N.W. 566 (Minn. 1884). An association's knowledge is in no way parasitic of its members and is "direct" within the meaning of the original source clause.

In this case, the Association pleaded that its members have "personal knowledge that defendant anesthesiologists have routinely billed Medicare for personal performance of anesthesia procedures in which they were *not* continuously involved or present." It further pleaded that its members "have personal knowledge of defendants' false claims by virtue of communications with defendants themselves, participation in the anesthesia procedures which were later fraudulently billed by the defendant anesthesiologist, and familiarity with hospital records disclosing defendants' fraud." The defendants' response is that the anesthetists did not have direct knowledge of the anesthesiologists' billing practices, which came to light in an audit.

There are two problems with the defendants' argument. First, the record shows that the anesthetists often did see the anesthesiologist filling out forms used for billing with misleading information. These observations would support an inference that the anesthesiologist submitted false bills.

Second, to qualify as an original source, a relator does not have to have personal knowledge of all elements of a cause of action. *Springfield Term. Ry.,* 14 F.3d at 656-67. Direct knowledge of the anesthesiologists' operating room practices would be enough. A false claim consists of a representation contrary to fact, made knowingly or recklessly. If the relator has direct knowledge of the true state of the facts, it can be an original source even though its knowledge of the misrepresentation is not first-hand. *Id.* We therefore conclude that the Association has not only independent, but also direct knowledge of the information in question within the meaning of section 3730(e)(4)(B).

The last statutory condition for qualifying as an original source is that the relator must have voluntarily provided the information to the government before filing suit. The defendants concede that the Association sent a copy of its antitrust complaint to the local Medicare Part B office several days after it filed the antitrust suit. The Association's attorney filed an affidavit saying he received a call from a Medicare representative within a few days after mailing the complaint. The representative said he was referring the complaint to the Justice Department. We conclude that the Association fulfilled the requirement that it provide the information to the government before filing suit.

The defendants urge us to adopt an additional requirement that the relator must have revealed the allegations to the government *before* the public disclosure in order to be an original source. This rule has been adopted by the District of Columbia and Sixth Circuits. *FPC-Boron Employees' Club,* 105 F.3d at 690-91; *McKenzie,* 123 F.3d at 943. This additional requirement has no textual basis in the statute. Moreover, the courts adopting this requirement

have justified it by arguing that after public disclosure, the relator has no utility to the government. *FPC-Boron Employees' Club,* 105 F.3d at 691 ("Once the information has been publicly disclosed, however, there is little need for the incentive provided by a qui tam action."). However, as we have seen, through the original source provisions Congress chose to reward persons who discovered and revealed fraud, rather than confiscating their claims. At the same time, Congress limited that beneficence by denying the bounty even to those who uncovered the fraud unless they had revealed it to the government before filing suit. Sec. 3730(e)(4)(B). We would change the balance Congress struck if we were to further restrict the class of those whose discoveries had been made public but who were nevertheless permitted to proceed as relators. We decline to adopt the proposed additional requirement.

We hold that the Association qualifies as an original source of the information on which its allegations are based. We have subject-matter jurisdiction over this case.

III.

The district court held that the Association lacked standing to pursue the qui tam claim because there was no pecuniary injury to the United States when the anesthesiologists allegedly billed for medically directing or personally performing cases without fulfilling the requirements for medical direction or personal performance. The district court went beyond the pleadings to examine the evidence on the injury issue. We therefore review this issue under the summary judgment standard, rather than limiting our inquiry to the pleadings. *See Lujan v. Defenders of Wildlife,* 504 U.S. 555, 561 (1992).

We review the district court's entry of summary judgment de novo, applying the same standard appropriate in the district court. *Breeding v. Arthur J. Gallagher & Co.*, 164 F.3d 1151, 1156 (8th Cir. 1999). Summary judgment is proper only if, taking the evidence in the light most favorable to the non-moving party, there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Id.*

After the date of the district court's decision, the Supreme Court decided *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765, 778, (2000), in which it held that "a *qui tam* relator under the [False Claims Act] has Article III standing." The Court identified two discrete injuries to the United States that are redressed through False Claims cases: "both the injury to its sovereignty arising from violation of its laws (which suffices to support a criminal lawsuit by the Government) and the proprietary injury resulting from the alleged fraud." *Id.* at 771. The Court held that a qui tam relator gained standing to assert the government's rights through a "partial assignment of the Government's damages claim." *Id.* at 773. The defendants contend that if there are no damages, a qui tam relator does not have standing to assert the government's claim for penalties. The United States, appearing as amicus, contends that the relator can pursue such a claim. We have no occasion to address this argument, since the district court erred in holding that the United States would have suffered no pecuniary injury even if the Association proved false claims. That holding was based on a misunderstanding of the payment rules.

The Association alleges that the anesthesiologists billed for medical direction in cases in which they fell short of the requirements for that designation. The district court

concluded that if the anesthesiologists had not billed these cases as medical direction, "[p]resumably" they could only have billed them as personally performed, which would have been even more expensive. This does not follow. The services of an anesthesiologist who was involved in some way with a case but failed to meet the requirements of personal performance or medical supervision were not reimbursable on a reasonable charge basis under Medicare as services to the patient. Instead, the anesthesiologist's services would be considered supervisory services furnished to the hospital, reimbursable to the hospital on a reasonable cost basis only. 42 C.F.R. § 405.552(b) (1983); 48 Fed. Reg. 8902, 8927 (March 2, 1983). The defendants contend that if the anesthesiologists were not billed as performing or directing the cases, the government would have had to pay the anesthetists for the same service and therefore there would have been no net loss to the government. Before 1989, anesthetists were not eligible for reasonable charge reimbursements for anesthesia services. 48 Fed. Reg. at 8927. After January 1, 1989, Medicare reimbursed for anesthetists' services, but at least for some of that time it paid a lower rate than it paid for anesthesiologists' anesthesia services. United States General Accounting Office Report to Congressional Committees, *Medicare Payments for Medically Directed Anesthesia Services Should Be Reduced* 24-27 (March 1992). The Association filed an affidavit asserting that anesthetists were paid less than anesthesiologists for performing cases personally during much of the relevant time period. Therefore, it is incorrect to conclude that the government would have paid the same for the services no matter whether they were billed as personally performed by an anesthesiologist or not. Additionally, the Association claims that in some cases the hospitals certified that it

was medically necessary for both an anesthesiologist and anesthetist to perform anesthesia on a single patient, with no concurrent cases, when in fact the anesthesiologist did not personally perform the case. In such cases, if the government paid the personal performance rate to both the anesthetist and the anesthesiologist, the government's cost would be doubled. These sorts of pecuniary injury plainly confer standing on the relator who alleges them. The district court's legal conclusion that the Association lacked standing was premised on a faulty understanding of the applicable regulations.

IV.

The Association also appeals the district court's entry of summary judgment against it on the merits of its suit.

The district court entered summary judgment against the Association on the merits of its claims to the extent the claims were based on anesthesiologists billing cases as "personally performed." The district court held that Medicare regulations in effect at the time in question were "susceptible" to the interpretation that an anesthesiologist need not have been continuously physically present in the operating room to bill a case as "personally performed." The court concluded that this ambiguity ruled out the possibility that the defendants knew they were presenting false claims when they billed for personal performance of the cases in which they were not continuously present.

The United States has filed an amicus brief taking strong exception to the proposition that one cannot make a false statement by verifying compliance with an ambiguous regulation so long as one's actions satisfied any possible interpretation of the regulation. The government's

argument finds support in the Ninth Circuit's recent case of *United States ex rel. Oliver v. Parsons Co.,* 195 F.3d 457, 460, 463 (9th Cir. 1999) (court's interpretation of ambiguous regulation determines whether claim of compliance with regulation was false), *cert. denied,* 530 U.S. 1228 (2000). The defendants fall back from this position, arguing that the district court "did not . . . hold that the ambiguity of the anesthesia regulations negated a finding of falsity." Instead, the defendants contend the district court held that "many considerations precluded a finding of intent."

The False Claims Act prohibits the *knowing* presentation of false claims for government payment or approval. 31 U.S.C. § 3729(a). The Act defines "knowing" and "knowingly" to mean that the actor had actual knowledge of the pertinent information or acted in deliberate ignorance or in reckless disregard of the truth or falsity of that information. Sec. 3729(b). The question on intent here is whether the defendants knew (or would have known absent deliberate blindness or reckless disregard) that their bills would lead the government to believe that they had provided services that they actually did not provide. If a statement alleged to be false is ambiguous, the government (or here, the relator) must establish the defendant's knowledge of the falsity of the statement, which it can do by introducing evidence of how the statement would have been understood in context. *See United States v. Garfinkel,* 29 F.3d 1253, 1256 (8th Cir. 1994) ("evidence offered at trial could potentially resolve any ambiguity on the face of the document"); *United States v. Anderson,* 579 F.2d 455, 460 (8th Cir. 1978) ("In light of these ambiguities . . . the government must negative any reasonable interpretation that would make the defendant's statement factually

correct."); *United States v. Mackby,* 261 F.3d 821, 827 (9th Cir. 2001) (False Claims Act violation consisted of filling in Medicare claim form contrary to instructions received in Medicare bulletins). If the Association shows the defendants certified compliance with the regulation knowing that the HCFA interpreted the regulations in a certain way and that their actions did not satisfy the requirements of the regulation as the HCFA interpreted it, any possible ambiguity of the regulations is water under the bridge. However, it is important to remember that the standard for liability is knowing, not negligent, presentation of a false claim. *Oliver,* 195 F.3d at 464-65.

The alleged ambiguity is limited to the meaning of the requirement in the 1992 regulation 42 C.F.R. § 414.46(c)(2)(ii), that an anesthesiologist must be "continuously involved" in a case in order to have personally performed an anesthesia case in which an anesthetist was also "involved." The defendants contend that there was confusion about what was required of an anesthesiologist in order to bill a case as personally performed or "AA." The record shows that up until September 1993, while there may have been some uncertainty about the interpretation of "continuously involved," the defendants were on notice of the possibility that they were expected to be present with the anesthetist in order to represent that they had personally performed a case. There is at least a question of fact as to their state of mind during this early period. During this time frame, defendant Allina's in-house lawyer advised that it was his understanding that an anesthesiologist had to be "continuously present" with the anesthetist to bill for personal performance. The same lawyer inquired of Travelers, the Medicare carrier for the Twin Cities area, whether an anesthesiologist had to be in the

operating room the whole time to bill a single case as personally performed. Travelers agreed to get an answer from HCFA to this question. The defendants contend that they considered this question settled by an HCFA memo, which Travelers relayed to its provider community in September 1993, and which Blue Cross, carrier for the St. Cloud area, relayed to its providers in April 1994. The memo stated:

> It has been reported that anesthesiologists will bill using the AA modifier even though they are outside the operating room performing other activities, such as pain blocks, doing pre or post operative evaluations, or administering and/or monitoring a labor epidural. For the anesthesiologist to bill using the AA modifier [for personally performed case] under these circumstances, he must be physically present in the operating suite while the [anesthetist] is attending to the case. If the anesthesiologist is not continuously involved with the case, then it is considered neither personally performed nor medically directed.

(emphasis added). The defendants introduced evidence that at least some of them relied on this memo in forming the belief that they could bill for personally performing cases despite leaving the operating room, so long as they were present in the operating suite, which they define as the area in the hospital where surgery takes place.

In response, the Association contends that it was not reasonable to read this memo as authorizing anesthesiologists to bill for personal performance when they were not in the room with the patient. The Association argues that the 1993 HCFA memorandum was not intended to authorize anesthesiologists to leave while an anesthetist

performed their one-on-one cases, so long as they stayed in the operating suite. Instead, as the HCFA pointed out in April 1996, the intended point of the 1993 memorandum was to emphasize that, whoever physically performed the work in a one-on-one case, the anesthesiologist had to be solely devoted to that case in order to bill it as personally performed. The 1996 HCFA memo reasoned: "It should be assumed that, if the physician leaves the operating room, he/she is performing other duties. If the physician leaves the operating room to perform any other duties, the anesthesia procedure may not be billed as personally performed."

A few months after Travelers' dissemination of the 1993 HCFA memorandum, a further memorandum from HCFA on the subject of personally performed procedures was published in the American Society of Anesthesiologists newsletter of April 1994. This memorandum made it clear that anesthesiologists were not to leave a patient during a personally performed procedure. The memo stated that an anesthesiologist performing *medical direction* of concurrent procedures could "momentarily leave that procedure and perform another physician service" so long as this did not occur during a demanding part of the procedure. The memo contrasted the requirements for medically directed procedures with those for *personally performed* procedures: "Of course, we have not extended this policy to the case in which the anesthesiologist is personally performing the case. The reason for this is rather obvious. The anesthesiologist who is billing for personal performance of the case must personally perform the case. In theory, there is no one else to hand the case to." The memo concluded by saying that if the anesthetist, rather than

the anesthesiologist was actually performing the case, then the anesthetist, rather than the anesthesiologist, should be paid for it. Thus, the time frame within which the 1993 HCFA memorandum could have been thought to have given the anesthesiologists permission to bill cases as personally performed when they were not immediately involved in the procedure was quite brief.

Even assuming that, for six months or so, the 1993 HCFA memorandum misled some defendants into believing that anesthesiologists could leave the operating room and still represent that they had personally performed the case, this would only rule out claims in which leaving the operating room was the only respect in which the anesthesiologist fell short of fulfilling the personal performance standard. The Association amassed a record that would support the conclusion that the anesthesiologists regularly fell short of the standard in other respects.

First, whether or not the anesthesiologists disqualified themselves per se from billing at the personal performance rate by absenting themselves from the operating room, various anesthetists testified by deposition and affidavit that the anesthesiologists did not merely step out of the room, but in fact were often gone for large periods of time and at crucial times.[14] For instance, anesthetist Drew

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[14] The Association's brief makes numerous general citations to vast tracts of the record, sometimes as much as three hundred pages to support a single assertion. Rule 28(e) of the Federal Rules of Appellate Procedure requires page references to the appendix or parts of the record or transcript to support factual assertions. We have in the past criticized counsel for violating this rule and have even refused to consider arguments not supported by proper citations. *E.g., Miller v. Citizens Security Group, Inc.*, 116 F.3d 343, 346 n.4 (8th Cir. 1997). We consider burying a needle in a haystack to amount to a violation of Rule

(Continued on following page)

Mathews testified that in heart operations billed as personally performed, for over ninety percent of the cases he worked on, the anesthesiologist was present less than fifty percent of the time. Mathews kept extensive records of anesthesiologists' presence during the cases he worked on. Genevieve Crofoot testified that in one-on-one cases, the anesthesiologists would perform the induction and never come back. Kathleen Antoline also said that the anesthesiologists "circled 1 [denoting personally performed] and that was the end of their participation directly with that patient with me."

Second, the Association's witnesses stated that the anesthesiologists billed as personally performing cases when they were unavailable for emergencies on the case. Sometimes they were in a completely different part of the hospital during the case or even left the hospital. Mary Buchanan said anesthesiologists would circle one but would be unavailable for emergencies or would even leave the building. Kathleen Antoline said that a quarter of the time when she paged for emergencies, no one would come. Bart Barry testified that he had a case in which the anesthesiologist billed one-to-one despite being gone for three hours; when he returned, he had a blanket and appeared to have just woken up. Barry said that when someone is sleeping, the person may not hear a page. One anesthesiologist, John Magdsick, testified that he would consider himself in personal attendance of a patient as long as he was anywhere in the hospital. Nothing in the

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28. In this case we conclude that the interest of justice requires us to search the record to make appropriate rulings; however, counsel's violation of Rule 28 has multiplied the effort and prolonged the time necessary to prepare this opinion.

HCFA memorandum could have led the defendants to think that they could bill a case as personally performed when they were not present in the operating suite or when they were not available for emergencies in the case.

Third, many of the cases cited in the complaint involved anesthesiologists billing for personal performance while doing other duties inconsistent with personal performance, such as billing a concurrent case. Gayle McKay testified that anesthesiologists at Abbott-Northwestern would routinely bill cases as personally performed when they had left the room to do other billable procedures with other patients. Other times, they would leave to do post-operative rounds. The Association also filed copies of records it contends were altered to conceal the fact that a case done concurrently with another was actually billed as personally performed. Additionally, the evidence of the anesthesiologists' protracted absences from the operating rooms may give rise to the reasonable inference that the anesthesiologists were actually engaged in other duties while they were gone from the room. The 1996 HCFA memo on this subject assumes that significant absence from the room during the surgery would indicate performance of other duties that would render personal performance billing inappropriate.

Defendants have certainly made no showing that they were led to believe that the kind of conduct outlined above qualified as the personal performance of an anesthesia case. They were not entitled to summary judgment on the allegations that they knowingly billed cases as personally performed when their services did not satisfy HCFA criteria for that designation.

V.

The district court also entered summary judgment on the merits of the Association's claim that the anesthesiologists failed to participate in patients' "emergence" from anesthesia. As outlined earlier, the Medicare regulations required that anesthesiologists billing for "medical direction" of anesthetists must satisfy seven requirements in each case. One of those requirements was personal participation in "the most demanding procedures in the anesthesia plan, including induction and emergence." 42 C.F.R. § 405.552(a)(1)(iii) (1983).

The Association produced witness after witness who said that the anesthesiologists at the hospitals where they worked routinely left after induction of anesthesia and did not return for emergence. The district court summarized this evidence: "[T]he record shows that anesthesiologists routinely left the operating room before the end of the procedure, often speaking with patients in the recovery room or by telephone hours or even days after their procedures."

The Association's witnesses said that emergence occurs at the end of the surgery, in the operating room, and involves removing the breathing tube, allowing the patient to wake up, determining that the patient is stable, and finally taking the patient to the recovery room and relinquishing him to the care of a non-anesthesia caregiver. The Association produced letters from the American Society of Anesthesiologists and an excerpt from an anesthesia textbook, which were all consistent with this definition of emergence. The Association also presented the expert report of William Birnie, who worked for the HCFA when it was drafting the regulations in question.

Birnie testified that the regulations were based on advice from the American Society of Anesthesiologists that emergence was a particularly demanding part of the anesthesia process and it occured at "the end of the case when the surgical procedure has been completed and the patient is being prepared by the anesthesiologist to be turned over to a non-anesthesia provider."

Despite this extensive record, the district court held that "the overwhelming majority of the evidence on the record relating to the medical definition of [emergence]" supports the defendants' contention that emergence goes on for days. Therefore, according to the district court, the anesthesiologists did not need to participate in the extubation, stabilization, and transfer to the recovery room in order to fulfill the requirements of medical direction. Apparently the district court chose to disregard a record full of evidence contrary to its factual conclusion. This is impermissible on summary judgment, and we must therefore reverse.

VI.

The district court also entered summary judgment against the Association on its conspiracy claim, holding that there was no evidence that the anesthesiologists and hospitals had conspired to present false claims. We agree. The Association limits its attack on this holding to a footnote, and it presents no significant evidence for reversal. Accordingly, the judgment of the district court is reversed, except insofar as it enters summary judgment for the defendants on Count III of the Third Amended Complaint, alleging conspiracy, and on that part of Count

V alleging conspiracy. In those two respects, the summary judgment is affirmed.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
FOURTH DIVISION

United States of America, *ex rel.* Minnesota Association of Nurse Anesthetists,

Plaintiff,

v.

Allina Health System Corp., Unity Hospital, Mercy Hospital, John Murphy, Midwest Anesthesiologists, P.A., Metropolitan Anesthesia Network, Allen Tank, Health Billing Systems, Inc., Thelma M. Albay, M.D., Gary Baggenstoss, M.D., Minda Castillejos, M.D., David Cumming, M.D., Teri Heil, M.D., Sang Hong, M.D., Ted Janossy, M.D., Raymond Kloepper, II, M.D., John Magdsick, M.D., Thomas Maggs, M.D., Thomas Polta, M.D., John Roseberg, M.D., Jai Suh, M.D., Mark Sperry, M.D., Jeffrey Yue, M.D., and John Rydberg M.D., St. Cloud Hospital, Anesthesia Associates of St. Cloud Ltd., Gary A. Boeke, M.D., Philip F. Boyle, M.D., L. Michael Espeland, M.D., Alan D. Espelien, M.D., Paul J. Halverson, M.D., Craig Johnson, M.D., Lanse C. Lang, M.D., A. Wade McMillan, M.D., William H. Rice, M.D., Allan Reitz, M.D.,

ORDER
Civil No. 4-96-734

(Filed Sep. 24, 1997)

Annette E. Zwick, M.D., Anesthesiology, P.A., Abbott Northwestern Hospital, Northwest Anesthesia, P.A., Bryce Beverlin, M.D., Richard Blomberg, M.D., Jean Boening, M.D., Mitchell Burke, M.D., Rajarao Dwarakanath, M.D., Richard Engwall, M.D., James Gayes, M.D., Luis Giron, M.D., Nancy Groves, M.D., Jonathan Gudman, M.D., Richard Johnson, M.D., John Lillehei, M.D., Robert McKlveen, M.D., Judith Meisner, M.D., Michael Menzel, M.D., James Musich, M.D., Mark Nissen, M.D., Xavier Pereira, M.D., David Plut, M.D., Jeffrey Shaw, M.D., Richard Skoog, M.D., William Stauffer, M.D., Ofelio Tiu, M.D., Robert Tronnier, M.D., John Wintermute, M.D., and [other unknown defendants], Does I through XX,

Defendants.

INTRODUCTION

The above-entitled matter is before the undersigned United States District Judge on Defendants' motion to dismiss pursuant to Federal Rules of Civil Procedure 12(b)(6) and 9(b). The matter initially came on for hearing before this Court on November 8, 1996 pursuant to Defendants' motions to dismiss for lack of subject matter jurisdiction under Rule 12(b)(1), failure to plead fraud with particularity under Rule 9(b), and failure to state a claim upon which relief may be granted under Rule 12(b)(6).

On March 3, 1997, this Court denied Defendants' motion to dismiss for lack of subject matter jurisdiction. The Court also denied without prejudice Defendants' motion to dismiss for failure to state a claim upon which relief may be granted. The Court, however, granted Plaintiffs leave to file an amended complaint.

After Plaintiffs filed their third amended complaint, the matter again came on for hearing before the undersigned Judge on July 16, 1997, pursuant to Defendants' motion to dismiss or, in the alternative, to certify this Court's jurisdictional decision for interlocutory appeal to the United States Court of Appeals for the Eighth Circuit. Although this Court certified its Order for interlocutory appeal in the interests of judicial economy, the Eighth Circuit declined to review the decision on August 29, 1997. As a result, Defendants' motions to dismiss are once again before this Court.

BACKGROUND

The Court's Order of March 3, 1997 provides a detailed description of the parties, the procedural history and the relevant facts involved in this case. To avoid redundancy, the Court incorporates those facts by reference.

DISCUSSION

I. Standard for a Motion to Dismiss

In considering a motion to dismiss, the pleadings are construed in a light most favorable to the nonmovant, and the facts alleged in the complaint must be taken as true. *Hamm v. Groose*, 15 F.3d 110, 112 (8th Cir. 1994); *Ossman*

v. Diana Corp., 825 F. Supp. 870, 879-80 (D. Minn. 1993). Any ambiguities concerning the sufficiency of the claims must be resolved in favor of the nonmovant. *Ossman*, 825 F. Supp. at 880. A complaint should be dismissed "only if it is clear that no relief can be granted under any set of facts that could be proved consistent with the allegations." *Frey v. City of Herculaneum*, 44 F.3d 667, 671 (8th Cir. 1995) (citations omitted); *Hafley v. Lohman*, 90 F.3d 264, 266 (8th Cir. 1996). "A motion to dismiss should be granted as a practical matter . . . only in the unusual case in which the nonmovant includes allegations that show on the face of the complaint that there is some insuperable bar to relief." *Frey*, 44 F.3d at 671.

II. General Requirements of Rule 9(b)

Defendants maintain the Plaintiffs' complaint should be dismissed because it fails to allege fraud with sufficient particularity to satisfy Rule 9(b). Federal Rule of Civil Procedure 9(b) provides that, "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally." The purpose of the rule is threefold: "(1) to inhibit the filing of a complaint as a pretext for discovery of unknown wrongs; (2) to protect defendants from the harm that results from charges of serious wrongdoing; and (3) to give defendants notice of the conduct complained of, enabling defendants to prepare a defense." *United States v. Napco Int'l, Inc.*, 835 F. Supp. 493, 495 (D. Minn. 1993) (citing *Coronet Ins. Co. v. Seyfarth*, 665 F. Supp. 661, 66 (N.D. Ill. 1987)).

Courts have recognized, however, that the pleading requirement under Rule 9(b) may be relaxed if the defendant controls information required for proper pleading. *U.S. ex rel. Stinson, Lyons v. Blue Cross*, 755 F. Supp. 1055, 1056 (S.D. Ga. 1990); *U.S. ex rel. Sanders v. East Alabama Healthcare Authority*, 953 F. Supp. 1404, 1413 (M.D. Alabama 1996). In addition, courts will require less specificity in the complaint if the fraudulent activity involves numerous transactions or the fraud occurred over a long period of time. *Terrell v. Childers*, 836 F. Supp. 468, 475 (N.D. Ill. 1993).

Rule 9(b) applies to alleged violations of the False Claims Act. *United States v. Napco Int'l, Inc.*, 835 F. Supp. at 945. The False Claims Act provides, in relevant part:

> Any person who –
>
> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
>
> (2) knowingly makes uses, or causes to be made or used, a false or fraudulent claim paid or approved by the Government;
>
> (3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid; or . . .
>
> (7) knowingly makes, uses or causes to be made, or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

> is liable to the United States Government for a civil penalty. . . .

31 U.S.C. § 3729(a)(1)-(3), (7).

(1) Counts I, II, and III

a) Rule 9(b) Pleading Requirements

As to counts I and II, Plaintiffs' third amended complaint provides a plethora of examples of allegedly fraudulent conduct by individual defendants including names, dates, and descriptions of procedures. These allegations are sufficiently particular to satisfy the pleading requirements under Rule 9(b).

In circumstances in which the plaintiff has limited access to information, courts have afforded plaintiffs more flexibility under Rule 9(b). *See, e.g., U.S. ex rel. Stinson, Lyons v. Blue Cross*, 755 F. Supp. at 1056. With respect to the hospital Defendants, Plaintiffs provide fewer examples to support counts I and II. In almost all cases, however, the examples provide specific information including names, dates, and descriptions of procedures. Plaintiffs maintain that they cannot provide more specific allegations regarding St. Cloud Hospital, because the detailed information is exclusively in Defendant St. Cloud Hospital's possession. Plaintiffs assert that they have knowledge of fraudulent billing practices at all of the Defendant hospitals including Defendant St. Cloud Hospital. Despite the absence of specific examples at St. Cloud Hospital, Plaintiffs provide an adequate description of the nature and subject matter of the alleged false claims. Plaintiffs have provided notice sufficient to allow Defendants to defend against the allegations. As such, Plaintiffs have satisfied the pleading requirements of Rule 9(b) with respect to all Defendants. *See United States, ex rel. Piacentile v.*

Wolk, 1995 WL 20833 at *4 (E.D. Pa. 1995) ("Where the allegations describe the nature and subject matter of the alleged misrepresentations, the requirements of 9(b) are satisfied").

As noted above, courts have recognized a more relaxed exception to the particularity requirements of Rule 9(b) when the necessary information is in the exclusive control of defendants. In light of this exception, the Court finds that Plaintiffs have also minimally satisfied the pleading requirements as to count III, which alleges a conspiracy to defraud the government in violation of § 3729(a)(3). It should be noted, however, that Plaintiffs will face a substantially greater burden to withstand a summary judgment motion as to count III.

Furthermore, the Court rejects Defendants' assertion that Plaintiffs' complaint should be dismissed because it relies exclusively on information gathered through the discovery process. Defendants rely on, *inter alia*, *U.S. ex rel. Stinson, Lyons, Gerlin & Bustamante, P.A. v. Blue Cross Blue Shield of Georgia*, 755 F. Supp. 1040, 1053 (S.D. Ga. 1990), for the proposition that "a complaint alleging fraud should be filed only after a wrong is *reasonably* believed to have occurred; it should seek redress for a wrong, not to find one." In its March Order, however, this Court acknowledged that Plaintiffs' allegations were based upon their own knowledge. Although Plaintiffs amended their complaint in an effort to plead with sufficient particularity, the basis of the complaint continues to be Plaintiffs' knowledge and reasonable belief.

b) Rule 12(b)(6)

In addition to their Rule 9(b) assertions, Defendants contend that Plaintiffs' complaint fails to state a claim upon which relief can be granted under Rule 12(b)(6). Defendant hospitals assert that Plaintiffs have failed to allege a violation of the False Claims Act. In support of this contention, Defendant hospitals maintain that Plaintiffs' claim is legally insufficient because it fails to show that Defendant hospitals violated 31 U.S.C. § 2729(a)(1), (2), or (3). Defendants assert that Plaintiffs' allegations even if true, would not constitute a violation of the False Claims Act. Defendant hospitals maintain that "facilitating" fraud, as Plaintiffs have alleged in this case, is not actionable conduct within the meaning of the Act. It is conceivable, however, that "facilitation" could "cause to be presented . . . a false or fraudulent claim" under § 3729(a)(1). Similarly, "facilitation" could implicate the Defendant hospitals under §§ 3729(a)(2) or (3). As such, plaintiffs' claims against Defendant hospitals are legally sufficient under Rule 12(b)(6) and excluding them on a motion to dismiss would be premature.

As discussed above, Plaintiffs' allegations regarding the individual Defendants satisfy the particularity requirements of Rule 9(b). Additionally, with respect to counts I, II, and III, the Court finds no other "insuperable bar to relief" regarding the alleged violations of individual Defendants. *See, e.g., Frey*, 44 F.3d at 671. Accordingly, the individual Defendants' motions to dismiss will be denied as to counts I, II, and III.

(2) Count IV

Defendants assert that count IV should be dismissed for failure to state a claim upon which relief may be granted under Rule 12(b)(6). Count IV of Plaintiffs' complaint alleges that Defendants violated 31 U.S.C. § 3729(a)(7), which makes it a crime to "knowingly make[s], use[s], or cause[s] to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government. . . ." Defendants maintain that Plaintiffs' complaint does not allege facts that suggest Defendants' were concealing, avoiding, or decreasing a payment obligation. Plaintiffs argue that Defendants' alleged pattern of continually submitting false claims was, in part, intended as a method to avoid an obligation to repay the Government for the same purportedly fraudulent submissions. Plaintiffs assert that each alleged submission of a false claim constitutes both a false claim for payment, in violation of § 3729(a)(1) and (2), and a claim for wrongful avoidance of (re)payment to the government, in violation of § 3729(a)(7).

The "plain meaning" of subsection (a)(7) does not support Plaintiffs' interpretation. Courts have characterized claims under (a)(7) as "reverse false claims." *Wilkins ex rel. United States v. State of Ohio*, 885 F. Supp. 1055, 1064 (S.D. Ohio 1995). In essence, Plaintiffs allege that Defendants simultaneously submitted a false claim and a "reverse false claim" through the same action. Defendants should not be liable for the submission of an allegedly false claim *and* for the receipt of the government's payment of the same allegedly false claim. This interpretation subjects Defendants to a gratuitous penalty for the same allegedly improper act. Nothing in Plaintiffs' complaint

suggests an independent basis for liability under subsection (a)(7). The alleged conduct of Defendants is within the purview of subsections (a)(1) and (2) rather than (7). Accordingly, count IV will be dismissed with respect to all Defendants.

(3) Count V

In count V, Plaintiffs allege that Defendant hospitals violated their provider agreements with Medicare and conspired with Defendant anesthesiologists to submit false claims to the government. Plaintiffs apparently allege that Defendant hospitals breached their contract with Medicare. Count V, which is articulated in vague terms, does not allege a violation of the False Claims Act, and no relief is requested under count V. Because count V does not include an alleged violation of the False Claims Act, Plaintiff lacks standing to assert a valid claim for breach of an agreement between the government and the Defendant hospitals. *See United States ex rel. Mayman v. Martin Marietta Corp.*, 894 F. Supp. 218, 225-26 (D.Md. 1995) (qui tam realtor's standing and recovery is limited to claims under the False Claims Act). Consequently, count V of Plaintiffs' complaint will be dismissed with prejudice as to all Defendants.

CONCLUSION

Based on the foregoing, and all of the files, records and proceedings herein, **IT IS HEREBY ORDERED** that:

1. Defendants' motions to dismiss counts I, II, and III are **DENIED**.

2. Defendants' motions to dismiss counts IV and V are **GRANTED**; counts IV and V are accordingly **DISMISSED WITH PREJUDICE**.

/s/ Ann D. Montgomery
Ann D. Montgomery
UNITED STATES DISTRICT JUDGE

Dated: 9/24/97

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

United States of America, *ex rel.*, Minnesota Association of Nurse Anesthetists,

Plaintiff,

v.

Allina Health System Corp., Unity Hospital, Mercy Hospital, John Murphy, Midwest Anesthesiologists, P.A., Metropolitan Anesthesia Network, Allen Tank, Health Billing Systems, Inc., Thelma M. Albay, M.D., Gary Baggenstoss, M.D., Minda Castillejos, M.D., David Cumming, M.D., Teri Heil, M.D., Sang Hong, M.D., Ted Janossy, M.D., Raymond Kloepper, II, M.D., John Magdsick, M.D., Thomas Maggs, M.D., Thomas Polta, M.D., John Roseberg, M.D., Jai Suh, M.D., Mark Sperry, M.D., Jeffrey Yue, M.D., John Rydberg M.D., St. Cloud Hospital, Anesthesia Associates of St. Cloud Ltd., Gary A. Boeke, M.D., Philip F. Boyle, M.D., L. Michael Espeland, M.D., Alan D. Espelien, M.D., Paul J. Halverson, M.D., Craig Johnson, M.D., Lanse C.

MEMORANDUM OPINION AND ORDER

Civil No. 4-96-734 ADM/AJB

(Filed March 17, 1999)

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Abbott Northwestern
Hospital, Northwest
Anesthesia, P.A., Bryce
Beverlin, M.D., Richard
Blomberg, M.D., Jean
Boening, M.D., Mitchell
Burke, M.D., Rajarano
Dwarakanath, M.D., Richard
Engwall, M.D., James Gayes,
M.D., Luis Giron, M.D.,
Nancy Groves, M.D.,
Jonathan Gudman, M.D.,
Richard Johnson, M.D., John
Lillehei, M.D., Robert
McKlveen, M.D., Judith
Meisner, M.D., Michael
Menzel, M.D., James Musich,
M.D., Mark Nissen, M.D.,
Xavier Pereira, M.D., David
Plut, M.D., Jeffrey Shaw,
M.D., Richard Skoog, M.D.,
William Stauffer, M.D.,
Ofelio Tiu, M.D., Robert
Tronnier, M.D., John
Wintermute, M.D., and
[other unknown defendants],
Does I through XX,

Defendants.

William S. Rosen, Rosen & Rosen, St. Paul, Minnesota;
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and Herbert J. Stern, Stern & Greenberg, attorneys for Plaintiffs.

Bradley G. Clary and David P. Graham, Oppenheimer, Wolff & Donnelly, Minneapolis, Minnesota, attorneys for Defendant Anesthesiology, P.A.

Thomas Fraser, Cynthia Jokela, and Laurie J. Miller, Fredrickson & Byron, P.A., Minneapolis, Minnesota, attorneys for Defendants Midwest Anesthesia, P.A., et al.

Kevin J. Hughes and Paul R., Hughes, Mathews & Didier, P.A., St. Cloud, Minnesota, attorneys for Defendant St. Cloud Hospital.

John D. French, Jay D. Christiansen, Richard A. Duncan, and Elizabeth Schmiesing, Faegre & Benson, Minneapolis, Minnesota, attorneys for Defendants Allina Health System Corp., Unity Hospital, Mercy Hospital, Abbott Northwestern Hospital, and John Murphy.

Charles N. Nauen and Eric Tostrud, Lockridge, Grindal, Nauen & Holstein, PLLP, Minneapolis, Minnesota, attorneys for Defendants Anesthesia Associates of St. Cloud, Ltd., et al.

John A. Cotter and Christopher K. Larus, Larkin, Hoffman, Daly & Lindgren, Ltd., Bloomington, Minnesota, attorneys for Northwest Anesthesia, P.A., et al.

Janice M. Symchych and Christopher T. Shaheen, Dorsey & Whitney, L.L.P., Minneapolis, Minnesota, attorneys for Defendants Allen Tank and Health Billing Systems, Inc.

I. INTRODUCTION

The above-entitled matter came on for hearing before the undersigned United States District Judge on December 8, 1998 pursuant to Defendants' Motion for Summary Judgment and Plaintiff's Motion for Partial Summary Judgment. For the reasons set forth below, Defendants' motion is granted; Plaintiff's motion is denied; and Plaintiff's claims are dismissed.

II. BACKGROUND

A. Parties

1. Plaintiff

Plaintiff, the Minnesota Association of Nurse Anesthetists ("MANA") is a Minnesota-based trade association of Certified Registered Nurse Anesthetists ("CRNAs"). *See* Pl. Second Amended Complaint, at ¶ 3. The Association was formed to promote and protect the interests of its members. *Id.*

2. Defendants

Defendants are comprised of various hospitals, administrators, anesthesiology practice groups, and medical doctor anesthesiologists. Defendants have been divided into six groups:

1. The "Allina" Defendants, comprised of: Allina, which is an integrated health care system; Unity and Mercy Hospital; and John Murphy, Vice President of Unity and Mercy Hospitals. *Id.* at ¶¶ 7-10.

2. The "Midwest Anesthesiologists, P.A." ("MAPA") Defendants, comprised of: MAPA, a professional association which provides anesthesia services to Unity and Mercy Hospitals, Metropolitan Anesthesia Network; Allen Tank, a business manager with MAPA; Health Billing Systems, a billing service for MAPA employees; and several doctor anesthesiologists who maintain privileges at Unity and/or Mercy Hospitals and who are members of MAPA – Thelma Albay; Gary Baggenstoss; Minda Castillejos; David Cumming; Teri Heil; Sang Hong; Ted Janossy; Raymond Kloepper; John Magdsick; Thomas Maggs; Thomas Polta; John Roseberg; Jai Suh; Mark Sperry; Jeffrey Yue; and John Rydberg. *Id.* at ¶¶ 11-16.

3. Defendant St. Cloud Hospital. *Id.* at ¶ 17.

4. The "St. Cloud Anesthesiologist" Defendants, comprised of: Anesthesia Associates of St. Cloud, a professional partnership whose anesthesiologist members maintain privileges at St. Cloud Hospital; and the doctor anesthesiologists of Anesthesia Associates – Gary Boeke; Philip Boyle; L. Michael Espeland; Alan Espelien; Paul Halverson; Craig Johnson; Lanse Lang; A. Wade McMillan; William Rice; Allan Reitz; and Annette Zwick. *Id.* at ¶¶ 18-19.

5. Defendant Anesthesiology, P.A., a professional association which provides anesthesia services. *Id.* at ¶ 21.

6. The "Abbott Northwestern" Defendants, comprised of: Abbott Northwestern Hospital ("Abbott"), a hospital owned by Defendant Allina; Northwest Anesthesia, P.A. ("NAPA"), a professional corporation which provides anesthesia services to Abbott; and doctor anesthesiologists who maintain privileges at Abbott and are members and/or employees of NAPA – Bryce Beverlin;

Richard Blomberg; Jean Boening; Mitchell Burke; Rajarano Dwarakanath; Richard Engwall; James Gayes; Luis Giron; Nancy Groves; Jonathan Gudman; Richard Jo[1] - son; John Lillehei; Robert McKlveen; Judith Meisner; Michael Menzel; James Musich; Mark Nissen; Xavier Pereira; David Plut; Jeffrey Shaw; Richard Skoog; William Stauffer; Ofelio Tiu; Robert Tronnier; and John Wintermute. *Id.* at ¶¶ 22-24. Plaintiff also named fictitious Defendants Does I through XX.

The Court's Order of March 3, 1997, provides a detailed description of the complicated facts and procedural history involved in this case. To avoid redundancy, the Court incorporates those facts by reference.

III. DISCUSSION

A. Subject Matter Jurisdiction

Throughout the litigation of the instance case, Defendants have contested subject matter jurisdiction under 31 U.S.C. § 3730(e)(4) of the False Claims Act. The Act provides:

> No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Officer report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

31 U.S.C. § 3730(e)(4)(A). In the March 3, 1997 Order, this Court ruled that assertion of subject matter jurisdiction

over this action was appropriate. After discussion of the split in the various federal circuit courts of appeals as to the proper test for jurisdiction over *qui tam* lawsuits, the Court adopted a construction of the phrase "based upon [publicly disclosed allegations]" expressed by the Fourth Circuit in *United States ex rel. Siller v. Becton Dickinson & Co.*, 21 F.3d 1339, 1348 (4th Cir. 1994), *cert. denied*, 513 U.S. 928 (1994).[1] The order was certified for interlocutory review, but the Eighth Circuit declined to rule on the issue at that juncture in the litigation.

In light of recent decisions by federal courts in four additional circuits, Defendants urge that the issue of subject matter jurisdiction be reconsidered. *See United States ex rel. Biddle v. Board of Trustees of Leland Stanford, Jr. University*, 147 F.3d 821 (9th Cir. 1998); *United States ex rel. McKenzie v. BellSouth Telecommunications, Inc.*, 123 F.3d 935, 938-940 (6th Cir. 1997); *United States ex rel. Lamars v. City of Green Bay*, 998 F. Supp. 971, 980 (E.D. Wis. 1998); and *Wercinski v. Int'l Business Machines Corp.*, 982 F. Supp. 449, 458-461 (S.D. Tex. 1997). After a careful review of these and other cases, the Court is now persuaded that Defendants' construction of the jurisdictional requirements of the False Claims Act is the correct standard. Under this standard, Plaintiff's claims lack subject matter jurisdiction and must be dismissed.

The *qui tam* provisions of the FCA allow a private individual to bring a civil action for violations of the Act, serving as a "realtor" on behalf of the United States

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[1] The uncertainty of the resolution of the issue was forecast in describing the investigation of the phrase "based upon" as "a journey into the netherworld of statutory construction." *See* 3/3/97 Order, at 15.

government. *See* 31 U.S.C. § 3730(b)(1). The government may recover treble damages from anyone who has committed a fraud upon the government, and the individual bringing the case may receive up to thirty percent of the money recovered. 31 U.S.C. § 3730(d)(2). The *qui tam* provisions, however, prohibit plaintiffs from bringing actions which are "based upon" publicly disclosed information unless the plaintiff is the "original source" of the information.[2] An analysis of the subject matter jurisdiction issue in this case requires answers to three questions: (1) was there a public disclosure of the information upon which Plaintiff's claims are based?; (2) is Plaintiff's *qui tam* Complaint "based upon" that public information?; and, (3) was Plaintiff the "original source" of the information? Each question will be addressed in turn.

1. Was There a Public Disclosure of Information Regarding Defendants' Allegedly Fraudulent Conduct?

In the March 3, 1997 Order, the Court determined that the allegations of fraud alleged by the Plaintiff were publicly disclosed in the complaint in the earlier antitrust action, as well as in a series of newspaper articles published before the filing of the *qui tam* lawsuit. *See* 3/3/97

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[2] Specifically, the jurisdictional bar of the FCA provides that:

> (B) For the purposes of this paragraph, "original source" means an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under this section which is based upon the information.

31 U.S.C. § 3730(e)(4)(B).

Memorandum Order and Opinion, at 14 (*citing United States ex rel. Fed. Recovery Servs. Inc. v. Crescent City E.M.S., Inc.*, 72 F.3d 447, 450 (5th Cir. 1995) (information contained in court filings in prior lawsuit was "publicly disclosed"); *United States ex rel. Rabuska v. Crane Co.*, 40 F.3d 1509, 1512 (8th Cir. 1994)); *United States ex rel. Houck v. Folding Carton Admin. Comm.*, 881 F.2d 494, 504 (7th Cir. 1989) (allegations contained in prior antitrust complaint were "publicly disclosed").[3]

2. Was Plaintiff's *Qui Tam* Complaint "Based Upon" the Publicly Disclosed Information?

Having found the allegations in MANA's FCA action were publicly disclosed, the Court is not deprived of jurisdiction unless MANA's action was "based upon" those public disclosures. In its March 3, 1997 Order, the Court accepted the position argued by MANA and supported by the Fourth Circuit's decision in *Siller*, 21 F.3d at 1339, that the phrase "based upon" means "derived from." At that time it was determined that the *qui tam* allegations were not directly "derived from" the complaint in the antitrust action or the newspaper articles, and jurisdiction was, therefore, not precluded. *See* 3/3/97 Order, at 15-19. Defendants have argued from the outset that the phrase

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[3] For the purpose of *qui tam* actions, "publicly disclosed" information is generally that which is equally as available to the realtor as to the general public, had they chosen to look at the facts. *See United States ex rel. Stinson v. Prudential Ins.*, 944 F.2d 1149, 1155-56 (3rd Cir. 1991); *United States ex rel. Doe v. John Doe Corp.*, 960 F.2d 318, 322 (2d Cir. 1992). The jurisdictional bar of the Act is given effect only when "the essential elements compromising that fraudulent transaction have been publicly disclosed so as to raise a reasonable inference of fraud." *Rabushka*, 40 F.3d at 1514.

should be interpreted more broadly, as meaning "same as" or "supported by." Under such an interpretation, Defendants maintain that the allegations in MANA's *qui tam* suit, even if not directly derived from the antitrust complaint or articles, should be dismissed if they merely duplicate the public document. In March 1997, Defendants drew support for this interpretation from decisions in the Tenth Circuit (*United States ex rel. Precision Co. v. Koch Indus., Inc.*, 971 F.2d 548, 552 (10th Cir. 1992)), the Eleventh Circuit (*Cooper v. Blue Cross and Blue Shield of Florida, Inc.*, 19 F.3d 562, 567 (11th Cir. 1994), and the D.C. Circuit (*United States ex rel. D.J. Findley v. FPC – Boron Employees' Club, et al.*, 105 F.3d 675, 682 (DC Cir. 1997), *cert. denied*, 118 S.Ct. 172 (1997)).

Since the March, 1997 ruling on this issue, federal courts in the Ninth Circuit (*Biddle*, 147 F.3d at 821), the Sixth Circuit (*McKenzie*, 123 F.3d at 938-940), the Seventh Circuit (*Lamars*, 998 F. Supp. at 980), and the Fifth Circuit (*Wercinski*, 982 F. Supp. at 458-461) have adopted the more expansive interpretation of the phrase "based upon." The mounting federal precedent[4] lends convincing support to Defendants' position which the Court now adopts as the more appropriate definition. Therefore, an inquiry must be made into whether MANA's *qui tam* allegations were "supported by" or "substantially similar" to the information in the publicly disclosed antitrust complaint.

The antitrust complaint, filed on or about November 8, 1994, more than a year before the *qui tam* action, included the following allegations:

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[4] Federal Courts in 7 of 8 Circuits to address the issue have now adopted this interpretation.

> [T]he defendant anesthesiologist groups and their co-conspirators have engaged in a widespread practice of fraudulently billing of anesthesia services in violation of . . . Federal statutes, including § 1128(a)(1)(A). Such violations include, but are not limited to, billing for services that they did not render, billing for operations at which they are not present and inaccurately designating operations as one-on-one for Medicare purposes.
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> * * *
>
> In particular, defendant NMA [sic] engaged in similar false billing practices and false claims in connection with the provision of anesthesia services at Abbott Northwestern Hospital. In particular, anesthesiologists who work for NMA and provide services at Abbott Northwestern have on numerous occasions billed for personally performing operations when they were only present in the operating room for a fraction of the actual anesthesia time . . . Similar statements confirm that anesthesiologists often left the operating room after starting cases late in the day and never returned. Realtor has also obtained and supplied to the Government numerous rejection documents reflecting operations or procedures which were billed by the defendant Abbott Northwestern anesthesiologists as "personally performed" which Realtor is informed and believed were false and fraudulent.

Antirust Complaint, at ¶¶ 66, 57. These allegations mirror the essential elements of the claims in Counts I and II of Plaintiff's Third Amended Complaint. The *qui tam* counts are clearly "substantially similar to" or "supported by" the

antitrust allegations. Because the allegations of fraud in the *qui tam* lawsuit were publicly disclosed in the filing of the antitrust action described in its accompanying press coverage, the Court lacks jurisdiction over the action unless Plaintiff can establish that it was an "original source" of those allegations. *See United States ex rel. Barth v. Ridgedale Elec., Inc.*, 44 F.3d 699, 702 (8th Cir. 1995); *United States ex rel. Springfield Terminal Ry. Co. v. Quinn*, 14 F.3d 645, 656 (D.C. Cir. 1994).

3. Was Plaintiff the "Original Source" of the Publicly Disclosed Information?

Even if the allegations in the *qui tam* suit were "based upon publicly disclosed" information, a Plaintiff may still proceed if it was the "original source" of the information – that is, "an individual who has direct and independent knowledge of the information on which the allegations are based *and* has voluntarily provided the information to the Government before filing an action under this section which is based upon the information." 31 U.S.C. § 3730(e)(4)(B) (emphasis added).

Courts have now been reluctant to allow organizations to proceed with claims based upon information compiled directly by the group's members. *See United States ex rel. Federal Recovery Services, Inc. v. Crescent City E.M.S., Inc.*, ___ F.3d ___, ___, 1995 WL 758545 (5th Cir. 1995) (dismissing action brought by corporation when information not collected by the corporation, but by its shareholders); *United States ex rel. Precision Co. v. Koch Indus., Inc.*, 971 F.2d 548, 554 (10th Cir. 1992), *cert. denied*, 507 U.S. 951 (1993) (dismissing complaint when information uncovered by corporation's shareholders). Plaintiff relies

upon cases where organizations have been permitted to proceed where the information upon which the complaint was based arose directly from an investigation conducted on behalf of the organization or company itself. *See United States ex rel. Springfield Terminal Ry. Co.*, 14 F.3d 645; *United States ex rel. Hartigan v. Palumbo Bros.*, 797 F. Supp. 624 (N.D. Ill. 1992). MANA did not directly acquire knowledge of the alleged fraud through its own institutional actions, but rather by the individual efforts of its members.

Plaintiff has not identified any case in which a trade association has been allowed to proceed as a *qui tam* plaintiff. Indeed, the posturing of this case undercuts the policy rationale underlying *qui tam* actions. The "whistleblower" case rewards an individual plaintiff or group of plaintiffs for publicly disclosing information regarding fraudulent activities, most often those of an employer. In order to compensate a whistleblower for the inherent job security risks he or she assumes for the public benefit, the FCA allows that party to recover a substantial portion of any damages recovered in the action. By allowing a collective association like MANA to proceed as the named Plaintiff, the individual CRNA's have not assumed the same direct risks undertaken by other whistleblowers.

The philosophy behind the creation of the *qui tam* action is to encourage an individual with personal knowledge of a public danger to notify the public of the clandestine activities of the offending party, without risk of exposure to economic peril or other forms of retaliation. In the matter at hand, the *qui tam* device is being used not to blow a whistle to save the public from a dangerous practice, but rather as a tool in a marketplace battle

between anesthesiologists and nurse anesthetists in their long-fought struggle over the allocation of health care dollars. The design of a *qui tam* action is to create an incentive to report fraud where traditionally there would be a disincentive to the reporting. Here, the Plaintiff beings its litigation armed with a financial incentive from the outset. This *qui tam* suit is being used as a sword to attack the actions of a competitor rather than a shield to protect the interests of a vulnerable individual. To allow a trade association to act as a *qui tam* plaintiff is beyond the intended scope and purpose of the FCA. As such, MANA could not have been an "original source" of the information as envisioned by Congress in drafting the Act.

B. Standing

Plaintiff also lacks standing to bring this action. Pursuant to Article III, Section 2 of the United States Constitution, a federal court may adjudicate a civil action only when the matter presents a "case or controversy." *See Valley Forge Christian College v. Americans United for Separation of Church & State, Inc.*, 454 U.S. 464, 471 (1982). Accordingly, the Supreme Court has held that a litigant must have "standing" to challenge the actions sought to be adjudicated in the lawsuit. *Id.*

To establish standing, a litigant must meet three requirements: (1) the plaintiff must suffer "injury-in-fact" that is "concrete and particularized" and "actual or imminent"; (2) there must be a causal connection between the injury and the action which is the subject of the lawsuit; and, (3) it must be likely that the injury asserted will be redressed by a favorable decision. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992).

The plaintiff in a *qui tam* suit, referred to as the "realtor," brings the action on behalf of the government. Reconciling the plaintiff's role as an agent of the real party-in-interest with the Constitutional standing requirements has proven difficult.

Courts have employed various modes of analysis to determine whether a *qui tam* plaintiff can constitutionally maintain a federal case. Some courts have held that, by paying the costs of the litigation, a *qui tam* plaintiff has suffered an injury which is redressable by the court. *See, e.g., United States ex rel. Kreindler & Kreindler v. United Technologies Corp.*, 985 F.2d 1148, 1154 (2d Cir. 1993), *cert. denied*, 508 U.S. 973 (1993). Others have determined that whistleblower plaintiffs suffer constitutional injury given the potential for retaliatory actions by their defendant employers. *See United States ex rel. Roby v. Boeing Co.*, 995 F. Supp. 790 (S.D. Ohio 1998). Finally, a number of appellate courts have explained that the *qui tam* plaintiff is an assignee of United States government – the real "party-in-interest." Under this theory, as long as the United States satisfies the standing requirements, a plaintiff may pursue the whistleblower claim. *See, e.g., United States ex rel. Hall v. Tribal Development Corp.*, 49 F.3d 1208, 1212-14 (7th Cir. 1994); *United States ex rel. Kelly v. Boeing Co.*, 9 F.3d 743, 748 (9th Cir. 1993); *United States ex rel. Milam v. University of Texas M.D. Anderson Cancer Center*, 961 F.2d 46, 49 (4th Cir. 1992). The latter mode of analysis is most consistent with the policy reasons justifying whistleblower suits. Thus, MANA's standing turns on whether the United States has suffered "injury-in-fact" as a result of the Defendants' alleged actions.

1. Did the United States Suffer Injury as a Result of the Billing of CRNA Services in Medical Necessity Cases?

Plaintiff argues that the FCA does not require actual damages as an element of the prima facie case. *See* Pl. Mem. in Opp. to Summ. J. at 27-28, n.22. The Act clearly states that a violator "is liable to the United States Government for . . . the amount of damages which the Government sustains because of the act of that person . . . " 31 U.S.C. § 3729(a). To survive this motion on standing grounds, Plaintiff must demonstrate the existence of a material fact as to whether the Government has actually been damaged.

Under 42 C.F.R. 414.46(2)(iii), Medicare will not pay CRNAs involved in single, non-concurrent procedures with anesthesiologists unless the hospital could certify that the involvement of both the CRNA and the anesthesiologist was "medically necessary." Plaintiff argues that the Defendant hospitals fraudulently billed for CRNA charges under an "improper modifier" when they billed the procedures as "medically directed" when they knew the anesthesiologists were not continuously present in the operating room. *See* Third Amended Complaint at ¶ 67. Plaintiff, however, does not suggest the form in which the claims should have been submitted to the Government. Presumably, Plaintiff argues that the hospitals should have billed these cases at a higher, non-medically directed rate. *See* Duncan Aff. I., at Ex. 35 (Pl. Ans. to Interrog. 7). Plaintiff has not responded to this aspect of Defendants' argument. When viewing Plaintiff's claims with regard to the medical necessity cases, there is no identified damage to the United States Government. The apparent thrust of Plaintiff's claim is that the Defendant hospitals were

underbilling Medicare when using the improper modifier of "medically directed."

2. Did the United States Government Suffer Injury as a Result of Defendants' Billing of 1:1 Cases as "Personally Performed" Procedures?

By billing 1:1 cases as "personally performed," even when the anesthesiologist left the operating room during the procedure, Plaintiff claims that the Defendants violated the False Claims Act. A close look at this allegation, however, also shows a lack of proof of actual damages suffered by the United States.

Prior to 1998, Health Care Financing Administration (HCFA), one of the government oversight bodies charged with Medicare administration, did not allow dual payment for the services of both an anesthesiologist and a CRNA for a single, nonconcurrent case, because the combined CRNA and anesthesiologist medical direction payment rate exceeded the personal performance rate for the anesthesiologist individually. The testimony of HCFA witnesses indicates that individual carriers had the discretion to divide the personal performance payment on a 1:1 case between the anesthesiologist and the CRNA, as long as the combined payment to the two providers did not exceed the personal performance rate for the anesthesiologist alone. *See* Cuca Depo. at 50-51, 88, 121-122; Menas Depo. at 146-147. As Defendants argue: "In other words, the Medicare program was willing to pay an amount equal to the [anesthesiologist] personal performance rate on a 1:1 case involving a CRNA, and it was up to the local carriers to decide how to divide this pie between the hospital or CRNA and the [anesthesiologist]." Def. Mem. in Supp. of Summ. J. at 52. Defendants correctly characterize the case

as a dispute over the division of the Medicare fund pie, rather than the submission of false claims.

A consideration of the evidence supporting the alleged false claims in 1:1 cases shows that the United States paid for the exact service rendered – personal performance of an anesthesiology procedure. The United States actually paid for the services of two providers at the personal performance rate of one. In actions under the FCA, the level of damages is not measured simply by what the offender billed, but rather by the amount the United States paid out over and above that which it would not have otherwise paid out if the claims had been accurate. *See United States v. Coop. Grain and Supply*, 476 F.2d 47, 62 (8th Cir. 1973). In the context of the 1:1 cases, the Court cannot discern, and Plaintiffs have not clearly articulated, any actual financial damage to the real party in interest – the United States Government.

Plaintiff has not produced evidence to support any actual damages suffered by the United States. In light of the heightened standing requirements set out by the Court in *Lujan*, 504 U.S. at 560, Plaintiff lacks the requisite standing to proceed.

C. Other Grounds For Dismissal

Assuming, *arguendo*, that MANA's case met the Constitutional standards for both jurisdiction and standing, it suffers other serious infirmities as well.

1. Intent to Submit False Claims

In order to support its allegation in Count I of the Third Amended Complaint, MANA must produce evidence

to show that both defendant anesthesiologists and defendant hospitals have knowingly presented, or caused to be presented, to officers or employees of the United States Government, false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1). *See United States ex rel. Glass v. Medtronic, Inc.*, 957 F.2d 605, 608 (8th Cir. 1992) (in surviving a motion to dismiss, a FCA plaintiff must show the claim was truly "false or fraudulent").

The Medicare regulations involving the billing of "1:1 cases" are susceptible to the interpretation asserted by Defendants – that continuous physical presence by the anesthesiologists is not required. *See* Def. Mem. in Supp. of Summ. J. at 77. In light of this ambiguity, the Plaintiff cannot prove that Defendants *knowingly* submitted false claims. *See United States ex rel. Hochman v. Nackman*, 1998 WL 264841, *7 (when undisputed evidence demonstrates that defendant believed his conduct authorized by government, fraudulent intent is lacking and plaintiff's action must be dismissed).

Even when viewed in the light most favorable to the Plaintiff, the record bears substantial evidence that Defendants billed in accordance with the advice given them by the Government agents – the Medicare carriers. *See Hindo v. University of Health Sciences*, 65 F.3d 608, 613 (7th Cir. 1995), *cert. denied*, 516 U.S. 1114 (1996) (reliance on statements made by Veterans Administration sufficient to nullify defendant's intent to submit a false claim). The confusion on the part of nationwide carriers, members of the anesthesiology and anesthetist professions, and even the HCFA itself demonstrates the need for clarification of the regulations. With such a wide range of reasonable interpretations, Plaintiff is unable to prove the

requisite "fraudulent intent" on the part of the Defendants to "knowingly" submit false claims.

2. Participation in Emergence

Plaintiff argues that the conflicting definitions of "emergence" posited by the two parties create a genuine issue of material fact. Among the seven criteria listed in the Medicare regulations is the requirement that anesthesiologists "personally participate in the most demanding procedures in the anesthesia plan, including . . . emergence." 56 Fed. Reg. 59623 (Nov. 25, 1991). Viewed in the light most favorable to the Plaintiff, the record shows that anesthesiologists routinely left the operating room before the end of the procedure, often speaking with patients in the recovery room or by telephone hours or even days after their procedures. Plaintiff argues that "emergence" – the process of "waking up" from the anesthetic, occurs in the operating room, at the close of the procedure. Under this interpretation, the anesthesiologists could not "personally participate" unless they were physically present in the operating room.

Plaintiff's argument has one major flaw: "emergence" is undefined in the regulations or the Interpretive Medicare Carriers Manual published by the HCFA. Plaintiffs have supplied a separate meaning of the term for use in billing purposes only. A traditional rule of statutory construction is that "where Congress has used technical words or terms of art, 'it [is] proper to explain them by reference to the art or science to which they [are] appropriate.'" *Corning Glass Works v. Brennan*, 417 U.S. 188, 201 (1974). Defendants argue that "emergence" is uniformly understood within the profession as a gradual

process which may last for varying lengths of time, depending upon factors including the age and size of the patient or the nature of the medical procedure conducted.[5] The overwhelming majority of the evidence on the record relating to the medical definition of the term supports Defendants' position. *See* Duncan Aff. III, at 1; Report of Bertram W. Coffer, M.D., Ex. 4, at 6; Report of James F. Arens, MD, Ex. 3, at 7; Deposition of Joseph Kraska, CRNA, at 136-137; Faye Leatherman, CRNA, at 310; Beradine Okonek, CRNA, at 42-43; *see also* Def. Mem. in Supp. of Summ. J., at 92-96. As emergence is not separately defined in the Medicare regulations, it was reasonable for Defendants to have applied the medical profession definition of the term, rather than Plaintiff's billing definition.

3. Plaintiff's Conspiracy Allegations

Count III of MANA's Third Amended Complaint alleges that "Defendant hospitals and anesthesiologists and their defendant agents have conspired to defraud the Government by obtaining or seeking to obtain allowance and payment of false or fraudulent claims . . . in violation of 31 U.S.C. § 3729(a)(3)." To survive summary judgment on a conspiracy count, a plaintiff must produce evidence

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[5] According to the report prepared by Dr. Bertram W. Coffer:

> [E]mergence is not a specific moment in time, but rather a process that involves the elimination of the anesthetic from the patient's body as the patient gradually recovers intellectual functioning. This process usually (but not always) begins in the operating room and extends hours or days thereafter.

Report of Bertram W. Coffer, M.D., Duncan Aff. III, Ex. 4, at 6.

of, inter alia, an agreement between the alleged conspirators – "a conscious commitment to a common scheme designed to achieve an unlawful objective." *Lovett v. General Motors Corp.*, 998 F.2d 575, 579 (8th Cir. 1993), *cert. denied,* 510 U.S. 752, 768 (1984). In considering the conspiracy count in Plaintiff's parallel antitrust case, it was determined that Plaintiff's evidence could not support the existence of an agreement to violate the antitrust laws. *See* 9/24/97 Order, at 6. Plaintiff has produced even less evidence of an agreement in this case.

Plaintiff has made a series of broad allegations that "the Defendants" engaged in a conspiracy to submit false claims. It has made this sweeping claim without any evidence specific to a particular defendant showing a conscious commitment to a concerted coordination of activities. *See Admiral Theatre Corp. v. Douglas Theatre Co.*, 437 F. Supp. 1268, 1287 (D. Neb. 1977), *aff'd*, 585 F.2d 877 (8th Cir. 1978). In order to survive summary judgment on a conspiracy claim, a plaintiff must meet this burden. *See Lovett*, 998 F.2d at 579.

Plaintiff's Count III consists of conclusory allegations that the Defendant hospitals and anesthesiologists conspired to defraud the United States government. Plaintiff has not produced any evidence that officials from Defendants Allina, St. Cloud, or the anesthesiologists ever met, let alone agreed to conspire to engage in a widespread scheme. Plaintiff proffers only inferential evidence that various defendants had the "opportunity" to conspire. *See* Pl. Mem. in Opp. to Summ. J., at 53-55.

For example, Plaintiff claims that AASC President Craig Johnson and MAPA billing manager Al Tank were close friends and neighbors; that the hospitals and the

anesthesiologists entered into routine contracts allocating profits from anesthetic procedures; and that the hospitals refused to require doctors to sign in and out of the operating room or wear beepers, thus minimizing documentation of the fraudulent activities. *Id.* To turn these otherwise innocuous facts into allegations of conspiratorial conduct is an impermissible stretch of facts. *See United States ex rel. El Amin v. George Washington University*, 26 F. Supp. 2d 162, 163 (D.D.C. 1998) (holding that conclusory statements regarding defendants conspiratorial intent, without specific evidence, do not constitute a conspiracy to defraud). Defendants' Motion for Summary Judgment on Plaintiff's Count III is granted.

IV. CONCLUSION

Based on the foregoing, and all the files, records, and proceedings herein, **IT IS HEREBY ORDERED** that:

1. Defendants' Motion for Summary Judgment of Plaintiff's claims is **GRANTED IN ITS ENTIRETY**;

2. Plaintiff's Motion for Partial Summary Judgment is **DENIED**; and,

3. Plaintiff's Third Amended Complaint is **DISMISSED WITH PREJUDICE.**

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: March 16, 1999

/s/ Ann D. Montgomery
Ann D. Montgomery
United States District Judge

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 99-2356	x	
	x	
Minnesota Association of Nurse Anesthetists, United States of America, ex rel.,	x	Appeal from the United States District Court for the District of Minnesota
Appellant,	x	
vs.	x	
Allina Health System Corp., et al.,	x	
Appellees.	x	

The motion to stay issuance of the mandate has been considered by the court and is denied.

(5120-010199)

May 23, 2002

Order Entered at the Direction of the Court:

Clerk, U.S. Court of Appeals, Eighth Circuit

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 99-2356	x	
	x	
Minnesota Association of Nurse Anesthetists,	x	
	x	
Appellant,	x	Order Denying Petition
	x	for Rehearing and for
vs.	x	Rehearing En Banc
Allina Health System Corp., et al.,	x	
	x	
	x	
Appellees.	x	

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

Judges Bowman, Loken, and Riley would grant the petition for rehearing en banc.

Judge Melloy took no part in the decision in this matter.

(5128-010199)

March 25, 2002

Order Entered at the Direction of the Court:

Clerk, U.S. Court of Appeals, Eighth Circuit

Statutory Provisions

Relevant Excerpts from the False Claims Act

31 U.S.C. § 3729 – False Claims

a) Liability for certain acts. – Any person who –

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

(4) has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

(5) authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

(7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person, except that if the court finds that –

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation; the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of the person. A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Knowing and knowingly defined. – For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information –

(1) has actual knowledge of the information;

(2) acts in deliberate ignorance of the truth or falsity of the information; or

(3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(c) Claim defined. – For purposes of this section, "claim" includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

(d) Exemption from disclosure. – Any information furnished pursuant to subparagraphs (A) through (C) of subsection (a) shall be exempt from disclosure under section 552 of Title 5.

(e) Exclusion. – This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

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31 U.S.C. § 3730 – Civil Actions for False Claims

(a) Responsibilities of the Attorney General. – The Attorney General diligently shall investigate a violation under section 3729. If the Attorney General finds that a person has violated or is violating section 3729,

the Attorney General may bring a civil action under this section against the person.

(b) Actions by private persons.

(1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Government shall –

(A) proceed with the action, in which case the action shall be conducted by the Government; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

(c) Rights of the parties to qui tam actions.

(1) If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2) (A) The Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.

(B) The Government may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

(C) Upon a showing by the Government that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the Government's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, such as –

(i) limiting the number of witnesses the person may call;

(ii) limiting the length of the testimony of such witnesses;

(iii) limiting the person's cross-examination of witnesses; or

(iv) otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the Government so requests, it shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts (at the Government's expense). When a person proceeds with the action, the court, without limiting the status and rights of the person initiating the action, may nevertheless permit the

Government to intervene at a later date upon a showing of good cause.

(4) Whether or not the Government proceeds with the action, upon a showing by the Government that certain actions of discovery by the person initiating the action would interfere with the Government's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than 60 days. Such a showing shall be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the Government has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subsection (b), the Government may elect to pursue its claim through any alternate remedy available to the Government, including any administrative proceeding to determine a civil money penalty. If any such alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights in such proceeding as such person would have had if the action had continued under this section. Any finding of fact or conclusion of law made in such other proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of the preceding sentence, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the United States, if all time for filing such an appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(d) Award to qui tam plaintiff.

(1) If the Government proceeds with an action brought by a person under subsection (b), such person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the proceeds. Any such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(2) If the Government does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the

action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the Government proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of section 3729 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under paragraph (1) or (2) of this subsection, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of section 3729, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the United States to continue the action, represented by the Department of Justice.

(4) If the Government does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(e) Certain actions barred.

(1) No court shall have jurisdiction over an action brought by a former or present member of the armed forces under subsection (b) of this section against a member of the armed forces arising out of such person's service in the armed forces.

(2) (A) No court shall have jurisdiction over an action brought under subsection (b) against a Member of Congress, a member of the judiciary, or a senior executive branch official if the action is based on evidence or information known to the Government when the action was brought.

(B) For purposes of this paragraph, "senior executive branch official" means any officer or employee listed in paragraphs (1) through (8) of section 101(f) of the Ethics in Government Act of 1978 (5 U.S.C. App.).

(3) In no event may a person bring an action under subsection (b) which is based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.

(4) (A) No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under this section which is based on the information.

(f) Government not liable for certain expenses. – The Government is not liable for expenses which a person incurs in bringing an action under this section.

(g) Fees and expenses to prevailing defendant. – In civil actions brought under this section by the United States, the provisions of section 2412(d) of Title 28 shall apply.

(h) Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

31 USC § 3731 – False Claims Procedure

(a) A subpena requiring the attendance of a witness at a trial or hearing conducted under section 3730 of this Title may be served at any place in the United States.

(b) A civil action under section 3730 may not be brought –

(1) more than 6 years after the date on which the violation of section 3729 is committed, or

(2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

(c) In any action brought under section 3730, the United States shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

(d) Notwithstanding any other provision of law, the Federal Rules of Criminal Procedure, or the Federal Rules of Evidence, a final judgment rendered in favor of the United States in any criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any action which involves the same transaction as in the criminal proceeding and which is brought under subsection (a) or (b) of section 3730.

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31 USC § 3732 – False Claims Jurisdiction

(a) Actions under section 3730. – Any action under section 3730 may be brought in any judicial district in which the defendant or, in the case of multiple defendants, any one defendant can be found, resides, transacts business, or in which any act proscribed by section 3729 occurred. A summons as required by the Federal Rules of Civil Procedure shall be issued by the appropriate district court and served at any place within or outside the United States.

(b) Claims under state law. – The district courts shall have jurisdiction over any action brought under the laws of any State for the recovery of funds paid by a State or local government if the action arises from the same transaction or occurrence as an action brought under section 3730.

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31 U.S.C. § 3733 – Civil Investigative Demands

(a) In general. –

(1) Issuance and service. – Whenever the Attorney General has reason to believe that any person may be in possession, custody, or control of any documentary material or information relevant to a false claims law investigation, the Attorney General may, before commencing a civil proceeding under section 3730 or other false claims law, issue in writing and cause to be served upon such person, a civil investigative demand requiring such person–

(A) to produce such documentary material for inspection and copying,

(B) to answer in writing written interrogatories with respect to such documentary material or information,

(C) to give oral testimony concerning such documentary material or information, or

(D) to furnish any combination of such material, answers, or testimony.

The Attorney General may not delegate the authority to issue civil investigative demands under this subsection. Whenever a civil investigative demand is an express demand for any product of discovery, the Attorney General, the Deputy Attorney General, or an Assistant Attorney General shall cause to be served, in any manner authorized by this section, a copy of such demand upon the person from whom the discovery was obtained and shall notify the person to whom such demand is issued of the date on which such copy was served.

(2) Contents and deadlines. –

(A) Each civil investigative demand issued under paragraph (1) shall state the nature of the conduct constituting the alleged violation of a false claims law which is under investigation, and the applicable provision of law alleged to be violated.

(B) If such demand is for the production of documentary material, the demand shall –

(i) describe each class of documentary material to be produced with such definiteness and certainty as to permit such material to be fairly identified;

(ii) prescribe a return date for each such class which will provide a reasonable

period of time within which the material so demanded may be assembled and made available for inspection and copying; and

(iii) identify the false claims law investigator to whom such material shall be made available.

(C) If such demand is for answers to written interrogatories, the demand shall–

(i) set forth with specificity the written interrogatories to be answered;

(ii) prescribe dates at which time answers to written interrogatories shall be submitted; and

(iii) identify the false claims law investigator to whom such answers shall be submitted.

(D) If such demand is for the giving of oral testimony, the demand shall –

(i) prescribe a date, time, and place at which oral testimony shall be commenced;

(ii) identify a false claims law investigator who shall conduct the examination and the custodian to whom the transcript of such examination shall be submitted;

(iii) specify that such attendance and testimony are necessary to the conduct of the investigation;

(iv) notify the person receiving the demand of the right to be accompanied by an

attorney and any other representative; and

(v) describe the general purpose for which the demand is being issued and the general nature of the testimony, including the primary areas of inquiry, which will be taken pursuant to the demand.

(E) Any civil investigative demand issued under this section which is an express demand for any product of discovery shall not be returned or returnable until 20 days after a copy of such demand has been served upon the person from whom the discovery was obtained.

(F) The date prescribed for the commencement of oral testimony pursuant to a civil investigative demand issued under this section shall be a date which is not less than seven days after the date on which demand is received, unless the Attorney General or an Assistant Attorney General designated by the Attorney General determines that exceptional circumstances are present which warrant the commencement of such testimony within a lesser period of time.

(G) The Attorney General shall not authorize the issuance under this section of more than one civil investigative demand for oral testimony by the same person unless the person requests otherwise or unless the Attorney General, after investigation, notifies that person in writing that an additional demand for oral testimony is necessary. The Attorney General may not, notwithstanding section 510 of Title 28, authorize

the performance, by any other officer, employee, or agency, of any function vested in the Attorney General under this subparagraph.

(b) Protected material or information. –

(1) In general. – A civil investigative demand issued under subsection (a) may not require the production of any documentary material, the submission of any answers to written interrogatories, or the giving of any oral testimony if such material, answers, or testimony would be protected from disclosure under –

(A) the standards applicable to subpoenas or subpoenas duces tecum issued by a court of the United States to aid in a grand jury investigation; or

(B) the standards applicable to discovery requests under the Federal Rules of Civil Procedure, to the extent that the application of such standards to any such demand is appropriate and consistent with the provisions and purposes of this section.

(2) Effect on other orders, rules, and laws. – Any such demand which is an express demand for any product of discovery supersedes any inconsistent order, rule, or provision of law (other than this section) preventing or restraining disclosure of such product of discovery to any person. Disclosure of any product of discovery pursuant to any such express demand does not constitute a waiver of any right or privilege which the person making such disclosure may be entitled to invoke to resist discovery of trial preparation materials.

(c) Service; jurisdiction. –

(1) By whom served. – Any civil investigative demand issued under subsection (a) may be served by a false claims law investigator, or by a United States marshal or a deputy marshal, at any place within the territorial jurisdiction of any court of the United States.

(2) Service in foreign countries. – Any such demand or any petition filed under subsection (j) may be served upon any person who is not found within the territorial jurisdiction of any court of the United States in such manner as the Federal Rules of Civil Procedure prescribe for service in a foreign country. To the extent that the courts of the United States can assert jurisdiction over any such person consistent with due process, the United States District Court for the District of Columbia shall have the same jurisdiction to take any action respecting compliance with the section by any such person that such court would have if such person were personally within the jurisdiction of such court.

(d) Service upon legal entities and natural persons. –

(1) Legal entities. – Service of any civil investigative demand issued under subsection (a) or of any petition filed under subsection (j) may be made upon a partnership, corporation, association, or other legal entity by –

(A) delivering an executed copy of such demand or petition to any partner, executive officer, managing agent, or general agent of the partnership, corporation, association, or entity, or to any agent authorized by appointment or by law to receive service of process on behalf of such partnership, corporation, association, or entity;

(B) delivering an executed copy of such demand or petition to the principal office or place of business of the partnership, corporation, association, or entity; or

(C) depositing an executed copy of such demand or petition in the United States mails by registered or certified mail, with a return receipt requested, addressed to such partnership, corporation, association, or entity at its principal office or place of business.

(2) Natural persons. – Service of any such demand or petition may be made upon any natural person by –

(A) delivering an executed copy of such demand or petition to the person; or

(B) depositing an executed copy of such demand or petition in the United States mails by registered or certified mail, with a return receipt requested, addressed to the person at the person's residence or principal office or place of business.

(e) Proof of service. – A verified return by the individual serving any civil investigative demand issued under subsection (a) or any petition filed under subsection (j) setting forth the manner of such service shall be proof of such service. In the case of service by registered or certified mail, such return shall be accompanied by the return post office receipt of delivery of such demand.

(f) Documentary material. –

(1) Sworn certificates. – The production of documentary material in response to a civil investigative demand served under this section shall be made under a sworn certificate, in such form as the demand designates, by –

(A) in the case of a natural person, the person to whom the demand is directed, or

(B) in the case of a person other than a natural person, a person having knowledge of the facts and circumstances relating to such production and authorized to act on behalf of such person.

The certificate shall state that all of the documentary material required by the demand and in the possession, custody, or control of the person to whom the demand is directed has been produced and made available to the false claims law investigator identified in the demand.

(2) Production of materials. – Any person upon whom any civil investigative demand for the production of documentary material has been served under this section shall make such material available for inspection and copying to the false claims law investigator identified in such demand at the principal place of business of such person, or at such other place as the false claims law investigator and the person thereafter may agree and prescribe in writing, or as the court may direct under subsection (j)(1). Such material shall be made so available on the return date specified in such demand, or on such later date as the false claims law investigator may prescribe in writing. Such person may, upon written agreement between the person and the false claims law investigator, substitute copies for originals of all or any part of such material.

(g) Interrogatories. – Each interrogatory in a civil investigative demand served under this section shall be answered separately and fully in writing under oath and shall be submitted under a sworn certificate, in such form as the demand designates, by –

(1) in the case of a natural person, the person to whom the demand is directed, or

(2) in the case of a person other than a natural person, the person or persons responsible for answering each interrogatory.

If any interrogatory is objected to, the reasons for the objection shall be stated in the certificate instead of an answer. The certificate shall state that all information required by the demand and in the possession, custody, control, or knowledge of the person to whom the demand is directed has been submitted. To the extent that any information is not furnished, the information shall be identified and reasons set forth with particularity regarding the reasons why the information was not furnished.

(h) Oral examinations. –

(1) Procedures. – The examination of any person pursuant to a civil investigative demand for oral testimony served under this section shall be taken before an officer authorized to administer oaths and affirmations by the laws of the United States or of the place where the examination is held. The officer before whom the testimony is to be taken shall put the witness on oath or affirmation and shall, personally or by someone acting under the direction of the officer and in the officer's presence, record the testimony of the witness. The testimony shall be taken stenographically and shall be transcribed. When the testimony is fully transcribed, the officer before whom the testimony is taken shall promptly transmit a copy of the transcript of the testimony to the custodian. This subsection shall not preclude the taking of testimony by any means authorized by, and in a manner consistent with, the Federal Rules of Civil Procedure.

(2) Persons present. – The false claims law investigator conducting the examination shall exclude from the place where the examination is held all persons except the person giving the testimony, the attorney for and any other representative of the person giving the testimony, the attorney for the Government, any person who may be agreed upon by the attorney for the Government and the person giving the testimony, the officer before whom the testimony is to be taken, and any stenographer taking such testimony.

(3) Where testimony taken. – The oral testimony of any person taken pursuant to a civil investigative demand served under this section shall be taken in the judicial district of the United States within which such person resides, is found, or transacts business, or in such other place as may be agreed upon by the false claims law investigator conducting the examination and such person.

(4) Transcript of testimony. – When the testimony is fully transcribed, the false claims law investigator or the officer before whom the testimony is taken shall afford the witness, who may be accompanied by counsel, a reasonable opportunity to examine and read the transcript, unless such examination and reading are waived by the witness. Any changes in form or substance which the witness desires to make shall be entered and identified upon the transcript by the officer or the false claims law investigator, with a statement of the reasons given by the witness for making such changes. The transcript shall then be signed by the witness, unless the witness in writing waives the signing, is ill, cannot be found, or refuses to sign. If the transcript is not signed by the witness within 30 days after being afforded a reasonable opportunity to examine it,

the officer or the false claims law investigator shall sign it and state on the record the fact of the waiver, illness, absence of the witness, or the refusal to sign, together with the reasons, if any, given therefor.

(5) Certification and delivery to custodian. – The officer before whom the testimony is taken shall certify on the transcript that the witness was sworn by the officer and that the transcript is a true record of the testimony given by the witness, and the officer or false claims law investigator shall promptly deliver the transcript, or send the transcript by registered or certified mail, to the custodian.

(6) Furnishing or inspection of transcript by witness. – Upon payment of reasonable charges therefor, the false claims law investigator shall furnish a copy of the transcript to the witness only, except that the Attorney General, the Deputy Attorney General, or an Assistant Attorney General may, for good cause, limit such witness to inspection of the official transcript of the witness' testimony.

(7) Conduct of oral testimony. –

(A) Any person compelled to appear for oral testimony under a civil investigative demand issued under subsection (a) may be accompanied, represented, and advised by counsel. Counsel may advise such person, in confidence, with respect to any question asked of such person. Such person or counsel may object on the record to any question, in whole or in part, and shall briefly state for the record the reason for the objection. An objection may be made, received, and entered upon the record when it is claimed

that such person is entitled to refuse to answer the question on the grounds of any constitutional or other legal right or privilege, including the privilege against self-incrimination. Such person may not otherwise object to or refuse to answer any question, and may not directly or through counsel otherwise interrupt the oral examination. If such person refuses to answer any question, a petition may be filed in the district court of the United States under subsection (j)(1) for an order compelling such person to answer such question.

(B) If such person refuses to answer any question on the grounds of the privilege against self-incrimination, the testimony of such person may be compelled in accordance with the provisions of part V of Title 18.

(8) Witness fees and allowances. – Any person appearing for oral testimony under a civil investigative demand issued under subsection (a) shall be entitled to the same fees and allowances which are paid to witnesses in the district courts of the United States.

(i) Custodians of documents, answers, and transcripts. –

(1) Designation. – The Attorney General shall designate a false claims law investigator to serve as custodian of documentary material, answers to interrogatories, and transcripts of oral testimony received under this section, and shall designate such additional false claims law investigators as the Attorney General determines from time to time to be necessary to serve as deputies to the custodian.

(2) Responsibility for materials; disclosure. –

(A) A false claims law investigator who receives any documentary material, answers to interrogatories, or transcripts of oral testimony under this section shall transmit them to the custodian. The custodian shall take physical possession of such material, answers, or transcripts and shall be responsible for the use made of them and for the return of documentary material under paragraph (4).

(B) The custodian may cause the preparation of such copies of such documentary material, answers to interrogatories, or transcripts of oral testimony as may be required for official use by any false claims law investigator, or other officer or employee of the Department of Justice, who is authorized for such use under regulations which the Attorney General shall issue. Such material, answers, and transcripts may be used by any such authorized false claims law investigator or other officer or employee in connection with the taking of oral testimony under this section.

(C) Except as otherwise provided in this subsection, no documentary material, answers to interrogatories, or transcripts of oral testimony, or copies thereof, while in the possession of the custodian, shall be available for examination by any individual other than a false claims law investigator or other officer or employee of the Department of Justice authorized under subparagraph (B). The prohibition in the preceding sentence on the availability of material, answers, or

transcripts shall not apply if consent is given by the person who produced such material, answers, or transcripts, or, in the case of any product of discovery produced pursuant to an express demand for such material, consent is given by the person from whom the discovery was obtained. Nothing in this subparagraph is intended to prevent disclosure to the Congress, including any committee or subcommittee of the Congress, or to any other agency of the United States for use by such agency in furtherance of its statutory responsibilities. Disclosure of information to any such other agency shall be allowed only upon application, made by the Attorney General to a United States district court, showing substantial need for the use of the information by such agency in furtherance of its statutory responsibilities.

(D) While in the possession of the custodian and under such reasonable terms and conditions as the Attorney General shall prescribe –

(i) documentary material and answers to interrogatories shall be available for examination by the person who produced such material or answers, or by a representative of that person authorized by that person to examine such material and answers; and

(ii) transcripts of oral testimony shall be available for examination by the person who produced such testimony, or by a representative of that person

authorized by that person to examine such transcripts.

(3) Use of material, answers, or transcripts in other proceedings. – Whenever any attorney of the Department of Justice has been designated to appear before any court, grand jury, or Federal agency in any case or proceeding, the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony received under this section may deliver to such attorney such material, answers, or transcripts for official use in connection with any such case or proceeding as such attorney determines to be required. Upon the completion of any such case or proceeding, such attorney shall return to the custodian any such material, answers, or transcripts so delivered which have not passed into the control of such court, grand jury, or agency through introduction into the record of such case or proceeding.

(4) Conditions for return of material. – If any documentary material has been produced by any person in the course of any false claims law investigation pursuant to a civil investigative demand under this section, and –

(A) any case or proceeding before the court or grand jury arising out of such investigation, or any proceeding before any Federal agency involving such material, has been completed, or

(B) no case or proceeding in which such material may be used has been commenced within a reasonable time after completion of the examination and analysis of all documentary material and other information assembled in the course of such

investigation, the custodian shall, upon written request of the person who produced such material, return to such person any such material (other than copies furnished to the false claims law investigator under subsection (f)(2) or made for the Department of Justice under paragraph (2)(B)) which has not passed into the control of any court, grand jury, or agency through introduction into the record of such case or proceeding.

(5) Appointment of successor custodians. – In the event of the death, disability, or separation from service in the Department of Justice of the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony produced pursuant to a civil investigative demand under this section, or in the event of the official relief of such custodian from responsibility for the custody and control of such material, answers, or transcripts, the Attorney General shall promptly –

(A) designate another false claims law investigator to serve as custodian of such material, answers, or transcripts, and

(B) transmit in writing to the person who produced such material, answers, or testimony notice of the identity and address of the successor so designated.

Any person who is designated to be a successor under this paragraph shall have, with regard to such material, answers, or transcripts, the same duties and responsibilities as were imposed by this section upon that person's predecessor in office, except that the successor shall not be held

responsible for any default or dereliction which occurred before that designation.

(j) Judicial proceedings. –

(1) Petition for enforcement. – Whenever any person fails to comply with any civil investigative demand issued under subsection (a), or whenever satisfactory copying or reproduction of any material requested in such demand cannot be done and such person refuses to surrender such material, the Attorney General may file, in the district court of the United States for any judicial district in which such person resides, is found, or transacts business, and serve upon such person a petition for an order of such court for the enforcement of the civil investigative demand.

(2) Petition to modify or set aside demand. –

(A) Any person who has received a civil investigative demand issued under subsection (a) may file, in the district court of the United States for the judicial district within which such person resides, is found, or transacts business, and serve upon the false claims law investigator identified in such demand a petition for an order of the court to modify or set aside such demand. In the case of a petition addressed to an express demand for any product of discovery, a petition to modify or set aside such demand may be brought only in the district court of the United States for the judicial district in which the proceeding in which such discovery was obtained is or was last pending. Any petition under this subparagraph must be filed –

(i) within 20 days after the date of service of the civil investigative demand,

or at any time before the return date specified in the demand, whichever date is earlier, or

(ii) within such longer period as may be prescribed in writing by any false claims law investigator identified in the demand.

(B) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (A), and may be based upon any failure of the demand to comply with the provisions of this section or upon any constitutional or other legal right or privilege of such person. During the pendency of the petition in the court, the court may stay, as it deems proper, the running of the time allowed for compliance with the demand, in whole or in part, except that the person filing the petition shall comply with any portions of the demand not sought to be modified or set aside.

(3) Petition to modify or set aside demand for product of discovery. –

(A) In the case of any civil investigative demand issued under subsection (a) which is an express demand for any product of discovery, the person from whom such discovery was obtained may file, in the district court of the United States for the judicial district in which the proceeding in which such discovery was obtained is or was last pending, and serve upon any false claims law investigator identified in the demand and upon the recipient of the demand, a petition for an order of such court to modify or set aside those portions of the demand requiring

production of any such product of discovery. Any petition under this subparagraph must be filed –

(i) within 20 days after the date of service of the civil investigative demand, or at any time before the return date specified in the demand, whichever date is earlier, or

(ii) within such longer period as may be prescribed in writing by any false claims law investigator identified in the demand.

(B) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (A), and may be based upon any failure of the portions of the demand from which relief is sought to comply with the provisions of this section, or upon any constitutional or other legal right or privilege of the petitioner. During the pendency of the petition, the court may stay, as it deems proper, compliance with the demand and the running of the time allowed for compliance with the demand.

(4) Petition to require performance by custodian of duties. – At any time during which any custodian is in custody or control of any documentary material or answers to interrogatories produced, or transcripts of oral testimony given, by any person in compliance with any civil investigative demand issued under subsection (a), such person, and in the case of an express demand for any product of discovery, the person from whom such discovery was obtained, may file, in the district court of the United States for the judicial district within which the office of such custodian is situated, and serve

upon such custodian, a petition for an order of such court to require the performance by the custodian of any duty imposed upon the custodian by this section.

(5) Jurisdiction. – Whenever any petition is filed in any district court of the United States under this subsection, such court shall have jurisdiction to hear and determine the matter so presented, and to enter such order or orders as may be required to carry out the provisions of this section. Any final order so entered shall be subject to appeal under section 1291 of Title 28. Any disobedience of any final order entered under this section by any court shall be punished as a contempt of the court.

(6) Applicability of federal rules of civil procedure. – The Federal Rules of Civil Procedure shall apply to any petition under this subsection, to the extent that such rules are not inconsistent with the provisions of this section.

(k) Disclosure exemption. – Any documentary material, answers to written interrogatories, or oral testimony provided under any civil investigative demand issued under subsection (a) shall be exempt from disclosure under section 552 of Title 5.

(l) Definitions. – For purposes of this section –

(1) the term "false claims law" means –

(A) this section and sections 3729 through 3732; and

(B) any Act of Congress enacted after the date of the enactment of this section which prohibits, or makes available to the United States in any court of the United States any civil remedy with respect to, any false claim against, bribery of, or corruption of any officer or employee of the United States;

(2) the term "false claims law investigation" means any inquiry conducted by any false claims law investigator for the purpose of ascertaining whether any person is or has been engaged in any violation of a false claims law;

(3) the term "false claims law investigator" means any attorney or investigator employed by the Department of Justice who is charged with the duty of enforcing or carrying into effect any false claims law, or any officer or employee of the United States acting under the direction and supervision of such attorney or investigator in connection with a false claims law investigation;

(4) the term "person" means any natural person, partnership, corporation, association, or other legal entity, including any State or political subdivision of a State;

(5) the term "documentary material" includes the original or any copy of any book, record, report, memorandum, paper, communication, tabulation, chart, or other document, or data compilations stored in or accessible through computer or other information retrieval systems, together with instructions and all other materials necessary to use or interpret such data compilations, and any product of discovery;

(6) the term "custodian" means the custodian, or any deputy custodian, designated by the Attorney General under subsection (i)(1); and

(7) the term "product of discovery" includes –

(A) the original or duplicate of any deposition, interrogatory, document, thing, result of the inspection of land or other property, examination, or admission, which is obtained by

any method of discovery in any judicial or administrative proceeding of an adversarial nature;

(B) any digest, analysis, selection, compilation, or derivation of any item listed in subparagraph (A); and

(C) any index or other manner of access to any item listed in subparagraph (A).

Relevant Excerpts from the Program Fraud Civil Remedies Act

31 U.S.C. § 3801 – Definitions

(a) For purposes of this chapter –

(1) "authority" means –

(A) an executive department;

(B) a military department;

(C) an establishment (as such term is defined in section 11(2) of the Inspector General Act of 1978) which is not an executive department; and

(D) the United States Postal Service;

(2) "authority head" means –

(A) the head of an authority; or

(B) an official or employee of the authority designated, in regulations promulgated by the head of the authority, to act on behalf of the head of the authority;

(3) "claim" means any request, demand, or submission –

(A) made to an authority for property, services, or money (including money representing grants, loans, insurance, or benefits);

(B) made to a recipient of property, services, or money from an authority or to a party to a contract with an authority –

(i) for property of services if the United States –

(I) provided such property or services;

(II) provided any portion of the funds for the purchase of such property or services; or

(III) will reimburse such recipient or party for the purchase of such property or services; or

(ii) for the payment of money (including money representing grants, loans, insurance, or benefits) if the United States –

(I) provided any portion of the money requested or demanded; or

(II) will reimburse such recipient or party for any portion of the money paid on such request or demand; or

(C) made to an authority which has the effect of decreasing an obligation to pay or account for property, services, or money, except that such term does not include any claim made in any return of tax imposed by the Internal Revenue Code of 1954;

(4) "investigating official" means an individual who –

(A) (i) in the case of an authority in which an Office of Inspector General is established by the Inspector General Act of 1978 or by any other Federal law, is the Inspector General of that authority or an officer or employee of such Office designated by the Inspector General;

(ii) in the case of an authority in which an Office of Inspector General is not established by the Inspector General Act of 1978 or by any other Federal law, is an officer or employee of the authority designated by the authority head to conduct investigations under section 3803(a)(1) of this Title; or

(iii) in the case of a military department, is the Inspector General of the Department of Defense or an officer or employee of the Office of Inspector General of the Department of Defense who is designated by the Inspector General; and

(B) who, if a member of the Armed Forces of the United States on active duty, is serving in grade O-7 or above or, if a civilian employee, is serving in a position for which the rate of basic pay is not less than the minimum rate of basic pay for grade GS-16 under the General Schedule;

(5) "knows or has reason to know", for purposes of establishing liability under section 3802, means that a person, with respect to a claim or statement –

(A) has actual knowledge that the claim or statement is false, fictitious, or fraudulent;

(B) acts in deliberate ignorance of the truth or falsity of the claim or statement; or

(C) acts in reckless disregard of the truth or falsity of the claim or statement, and no proof of specific intent to defraud is required;

(6) "person" means any individual, partnership, corporation, association, or private organization;

(7) "presiding officer" means –

(A) in the case of an authority to which the provisions of subchapter II of chapter 5 of Title 5 apply, an administrative law judge appointed in the authority pursuant to section 3105 of such Title or detailed to the authority pursuant to section 3344 of such Title; or

(B) in the case of an authority to which the provisions of such subchapter do not apply, an officer or employee of the authority who –

(i) is selected under chapter 33 of Title 5 pursuant to the competitive examination process applicable to administrative law judges;

(ii) is appointed by the authority head to conduct hearings under section 3803 of this Title;

(iii) is assigned to cases in rotation so far as practicable;

(iv) may not perform duties inconsistent with the duties and responsibilities of a presiding officer;

(v) is entitled to pay prescribed by the Office of Personnel Management independently of ratings and recommendations made by the authority and in accordance with chapter 51 of such Title and subchapter III of chapter 53 of such Title;

(vi) is not subject to performance appraisal pursuant to chapter 43 of such Title; and

(vii) may be removed, suspended, furloughed, or reduced in grade or pay only for good cause established and determined by the Merit Systems Protection Board on the record after opportunity for hearing by such Board;

(8) "reviewing official" means any officer or employee of an authority –

(A) who is designated by the authority head to make the determination required under section 3803(a)(2) of this Title;

(B) who, if a member of the Armed Forces of the United States on active duty, is serving in grade O-7 or above or, if a civilian employee, is serving in a position for which the rate of basic pay is not less than the minimum rate of basic pay for grade GS-16 under the General Schedule; and

(C) who is –

(i) not subject to supervision by, or required to report to, the investigating official; and

(ii) not employed in the organizational unit of the authority in which the investigating official is employed; and

(9) "statement" means any representation, certification, affirmation, document, record, or accounting or bookkeeping entry made –

(A) with respect to a claim or to obtain the approval or payment of a claim (including relating to eligibility to make a claim); or

(B) with respect to (including relating to eligibility for) –

(i) a contract with, or a bid or proposal for a contract with; or

(ii) a grant, loan, or benefit from, an authority, or any State, political subdivision of a State, or other party, if the United States Government provides any portion of the money or property under such contract or for such grant, loan, or benefit, or if the Government will reimburse such State, political subdivision, or party for any portion of the money or property under such contract or for such grant, loan, or benefit, except that such term does not include any statement made in any return of tax imposed by the Internal Revenue Code of 1954.

(b) For purposes of paragraph (3) of subsection (a) –

(1) each voucher, invoice, claim form, or other individual request or demand for property, services, or money constitutes a separate claim;

(2) each claim for property, services, or money is subject to this chapter regardless of whether

such property, services, or money is actually delivered or paid; and

(3) a claim shall be considered made, presented, or submitted to an authority, recipient, or party when such claim is actually made to an agent, fiscal intermediary, or other entity, including any State or political subdivision thereof, acting for or on behalf of such authority, recipient, or party.

(c) For purposes of paragraph (9) of subsection (a) –

(1) each written representation, certification, or affirmation constitutes a separate statement; and

(2) a statement shall be considered made, presented, or submitted to an authority when such statement is actually made to an agent, fiscal intermediary, or other entity, including any State or political subdivision thereof, acting for or on behalf of such authority.

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31 U.S.C. § 3802 – False Claims and Statements – Liability.

(a) (1) Any person who makes, presents, or submits, or causes to be made, presented, or submitted, a claim that the person knows or has reason to know –

(A) is false, fictitious, or fraudulent;

(B) includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;

(C) includes or is supported by any written statement that –

(i) omits a material fact;

(ii) is false, fictitious, or fraudulent as a result of such omission; and

(iii) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or

(D) is for payment for the provision of property or services which the person has not provided as claimed;

shall be subject to, in addition to any other remedy that may be prescribed by law, a civil penalty of not more than $5,000 for each such claim. Except as provided in paragraph (3) of this subsection, such person shall also be subject to an assessment, in lieu of damages sustained by the United States because of such claim, of not more than twice the amount of such claim, or the portion of such claim, which is determined under this chapter to be in violation of the preceding sentence.

(2) Any person who makes, presents, or submits, or causes to be made, presented, or submitted, a written statement that –

(A) the person knows or has reason to know –

(i) asserts a material fact which is false, fictitious, or fraudulent; or

(ii) (I) omits a material fact; and

(II) is false, fictitious, or fraudulent as a result of such omission;

(B) in the case of a statement described in clause (ii) of subparagraph (A), is a statement in which the person making, presenting, or

submitting such statement has a duty to include such material fact; and

(C) contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement,

shall be subject to, in addition to any other remedy that may be prescribed by law, a civil penalty of not more than $5,000 for each such statement.

(3) An assessment shall not be made under the second sentence of paragraph (1) with respect to a claim if payment by the Government has not been made on such claim.

(b) (1) Except as provided in paragraphs (2) and (3) of this subsection –

(A) a determination under section 3803(a)(2) of this Title that there is adequate evidence to believe that a person is liable under subsection (a) of this section; or

(B) a determination under section 3803 of this Title that a person is liable under subsection (a) of this section;

may provide the authority with grounds for commencing any administrative or contractual action against such person which is authorized by law and which is in addition to any action against such person under this chapter.

(2) A determination referred to in paragraph (1) of this subsection may be used by the authority, but shall not require such authority, to commence any administrative or contractual action which is authorized by law.

(3) In the case of an administrative or contractual action to suspend or debar any person who is

eligible to enter into contracts with the Federal Government, a determination referred to in paragraph (1) of this subsection shall not be considered as a conclusive determination of such person's responsibility pursuant to Federal procurement laws and regulations

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31 U.S.C. § 3803 – Hearing and Determinations

(a) (1) The investigating official of an authority may investigate allegations that a person is liable under section 3802 of this Title and shall report the findings and conclusions of such investigation to the reviewing official of the authority. The preceding sentence does not modify any responsibility of an investigating official to report violations of criminal law to the Attorney General.

(2) If the reviewing official of an authority determines, based upon the report of the investigating official under paragraph (1) of this subsection, that there is adequate evidence to believe that a person is liable under section 3802 of this Title, the reviewing official shall transmit to the Attorney General a written notice of the intention of such official to refer the allegations of such liability to a presiding officer of such authority. Such notice shall include –

(A) a statement of the reasons of the reviewing official for the referral of such allegations;

(B) a statement specifying the evidence which supports such allegations;

(C) a description of the claims or statements for which liability under section 3802 of this Title is alleged;

(D) an estimate of the amount of money or the value of property or services requested or demanded in violation of section 3802 of this Title; and

(E) a statement of any exculpatory or mitigating circumstances which may relate to such claims or statements.

(b) (1) Within 90 days after receipt of a notice from a reviewing official under paragraph (2) of subsection (a), the Attorney General or an Assistant Attorney General designated by the Attorney General shall transmit a written statement to the reviewing official which specifies –

(A) that the Attorney General or such Assistant Attorney General approves or disapproves the referral to a presiding officer of the allegations of liability stated in such notice;

(B) in any case in which the referral of allegations is approved, that the initiation of a proceeding under this section with respect to such allegations is appropriate; and

(C) in any case in which the referral of allegations is disapproved, the reasons for such disapproval.

(2) A reviewing official may refer allegations of liability to a presiding officer only if the Attorney General or an Assistant Attorney General designated by the Attorney General approves the referral of such allegations in a written statement described in paragraph (1) of this subsection.

(3) If the Attorney General or an Assistant Attorney General designated by the Attorney General transmits to an authority head a written finding that the continuation of any hearing under this section with respect to a claim or statement may adversely affect any pending or potential criminal or civil action related to such claim or statement, such hearing shall be immediately stayed and may be resumed only upon written authorization of the Attorney General.

(c) (1) No allegations of liability under section 3802 of this Title with respect to any claim made, presented, or submitted by any person shall be referred to a presiding officer under paragraph (2) of subsection (b) if the reviewing official determines that –

(A) an amount of money in excess of $150,000; or

(B) property or services with a value in excess of $150,000, is requested or demanded in violation of section 3802 of this Title in such claim or in a group of related claims which are submitted at the time such claim is submitted.

(2) (A) Except as provided in subparagraph (B) of this paragraph, no allegations of liability against an individual under section 3802 of this Title with respect to any claim or statement made, presented, or submitted, or caused to be made, presented, or submitted, by such individual relating to any benefits received by such individual shall be referred to a presiding officer under paragraph (2) of subsection (b).

(B) Allegations of liability against an individual under section 3802 of this Title with respect

to any claim or statement made, presented, or submitted, or caused to be made, presented, or submitted, by such individual relating to any benefits received by such individual may be referred to a presiding officer under paragraph (2) of subsection (b) if –

(i) such claim or statement is made by such individual in making application for such benefits;

(ii) such allegations relate to the eligibility of such individual to receive such benefits; and

(iii) with respect to such claim or statement, the individual –

(I) has actual knowledge that the claim or statement is false, fictitious, or fraudulent;

(II) acts in deliberate ignorance of the truth or falsity of the claim or statement; or

(III) acts in reckless disregard of the truth or falsity of the claim or statement.

(C) For purposes of this subsection, the term "benefits" means –

(i) benefits under the supplemental security income program under Title XVI of the Social Security Act;

(ii) old age, survivors, and disability insurance benefits under Title II of the Social Security Act;

(iii) benefits under Title XVIII of the Social Security Act;

(iv) assistance under a State program funded under part A of Title IV of the Social Security Act [section 601 et seq. of Title 42];

(v) medical assistance under a State plan approved under section 1902(a) of the Social Security Act;

(vi) benefits under Title XX of the Social Security Act;

(vii) benefits under the Food Stamp Program (as defined in section 3(h) of the Food Stamp Act of 1977);

(viii) benefits under chapters 11, 13, 15, 17, and 21 of Title 38;

(ix) benefits under the Black Lung Benefits Act;

(x) benefits under the special supplemental nutrition program for women, infants, and children established under section 17 of the Child Nutrition Act of 1966;

(xi) benefits under section 336 of the Older Americans Act;

(xii) any annuity or other benefit under the Railroad Retirement Act of 1974;

(xiii) benefits under the Richard B. Russell National School Lunch Act;

(xiv) benefits under any housing assistance program for lower income families or elderly or handicapped persons which is administered by the Secretary of Housing and Urban Development or the Secretary of Agriculture;

(xv) benefits under the Low-Income Home Energy Assistance Act of 1981; and

(xvi) benefits under part A of the Energy Conservation in Existing Buildings Act of 1976,

which are intended for the personal use of the individual who receives the benefits or for a member of the individual's family.

(d) (1) On or after the date on which a reviewing official is permitted to refer allegations of liability to a presiding officer under subsection (b) of this section, the reviewing official shall mail, by registered or certified mail, or shall deliver, a notice to the person alleged to be liable under section 3802 of this Title. Such notice shall specify the allegations of liability against such person and shall state the right of such person to request a hearing with respect to such allegations.

(2) If, within 30 days after receiving a notice under paragraph (1) of this subsection, the person receiving such notice requests a hearing with respect to the allegations contained in such notice –

(A) the reviewing official shall refer such allegations to a presiding officer for the commencement of such hearing; and

(B) the presiding officer shall commence such hearing by mailing by registered or certified

mail, or by delivery of, a notice which complies with paragraphs (2)(A) and (3)(B)(i) of subsection (g) to such person.

(e) (1) (A) Except as provided in subparagraph (B) of this paragraph, at any time after receiving a notice under paragraph (2)(B) of subsection (d), the person receiving such notice shall be entitled to review, and upon payment of a reasonable fee for duplication, shall be entitled to obtain a copy of, all relevant and material documents, transcripts, records, and other materials, which relate to such allegations and upon which the findings and conclusions of the investigating official under paragraph (1) of subsection (a) are based.

(B) A person is not entitled under subparagraph (A) to review and obtain a copy of any document, transcript, record, or material which is privileged under Federal law.

(2) At any time after receiving a notice under paragraph (2)(B) of subsection (d), the person receiving such notice shall be entitled to obtain all exculpatory information in the possession of the investigating official or the reviewing official relating to the allegations contained in such notice. The provisions of subparagraph (B) of paragraph (1) do not apply to any document, transcript, record, or other material, or any portion thereof, in which such exculpatory information is contained.

(f) Any hearing commenced under paragraph (2) of subsection (d) shall be conducted by the presiding officer on the record in order to determine –

(1) the liability of a person under section 3802 of this Title; and

(2) If a person is determined to be liable under such section, the amount of any civil penalty or assessment to be imposed on such person.

Any such determination shall be based on the preponderance of the evidence.

(g) (1) Each hearing under subsection (f) of this section shall be conducted –

(A) In the case of an authority to which the provisions of subchapter II of chapter 5 of Title 5 apply, in accordance with –

(i) the provisions of such subchapter to the extent that such provisions are not inconsistent with the provisions of this chapter; and

(ii) procedures promulgated by the authority head under paragraph (3) of this subsection; or

(B) in the case of an authority to which the provisions of such subchapter do not apply, in accordance with procedures promulgated by the authority head under paragraphs (2) and (3) of this subsection.

(2) An authority head of an authority described in subparagraph (B) of paragraph (1) shall by regulation promulgate procedures for the conduct of hearings under this chapter. Such procedures shall include:

(A) The provision of written notice of the hearing to any person alleged to be liable under section 3802 of this Title, including written notice of –

(i) the time, place, and nature of the hearing;

(ii) the legal authority and jurisdiction under which the hearing is to be held; and

(iii) the matters of facts and law to be asserted.

(B) The provision to any person alleged to be liable under section 3802 of this Title of opportunities for the submission of facts, arguments, offers of settlement, or proposals of adjustment.

(C) Procedures to ensure that the presiding officer shall not, except to the extent required for the disposition of ex parte matters as authorized by law –

(i) consult a person or party on a fact in issue, unless on notice and opportunity for all parties to the hearing to participate; or

(ii) be responsible to or subject to the supervision or direction of the investigating official or the reviewing official.

(D) Procedures to ensure that the investigating official and the reviewing official do not participate or advise in the decision required under subsection (h) of this section or the review of the decision by the authority head under subsection (i) of this section, except as provided in subsection (j) of this section.

(E) The provision to any person alleged to be liable under section 3802 of this Title of opportunities to present such person's case through oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts.

(F) Procedures to permit any person alleged to be liable under section 3802 of this Title to be accompanied, represented, and advised by counsel or such other qualified representative as the authority head may specify in such regulations.

(G) Procedures to ensure that the hearing is conducted in an impartial manner, including procedures to –

(i) permit the presiding officer to at any time disqualify himself; and

(ii) permit the filing, in good faith, of a timely and sufficient affidavit alleging personal bias or another reason for disqualification of a presiding officer or a reviewing official.

(3) (A) Each authority head shall promulgate by regulation procedures described in subparagraph (B) of this paragraph for the conduct of hearings under this chapter. Such procedures shall be in addition to the procedures described in paragraph (1) or paragraph (2) of this subsection, as the case may be.

(B) The procedures referred to in subparagraph (A) of this paragraph are:

(i) Procedures for the inclusion, in any written notice of a hearing under this section to any person alleged to be liable under section 3802 of this Title, of a description of the procedures for the conduct of the hearing.

(ii) Procedures to permit discovery by any person alleged to be liable under section 3802 of this Title only to the extent that the presiding officer determines that such discovery is necessary for the expeditious, fair, and reasonable consideration of the issues, except that such procedures shall not apply to documents, transcripts, records, or other material which a person is entitled to review under paragraph (1) of subsection (e) or to information to which a person is entitled under paragraph (2) of such subsection. Procedures promulgated under this clause shall prohibit the discovery of the notice required under subsection (a)(2) of this section.

(4) Each hearing under subsection (f) of this section shall be held –

(A) in the judicial district of the United States in which the person alleged to be liable under section 3802 of this Title resides or transacts business;

(B) in the judicial district of the United States in which the claim or statement upon which the allegation of liability under such section was made, presented, or submitted; or

(C) in such other place as may be agreed upon by such person and the presiding officer who will conduct such hearing.

(h) The presiding officer shall issue a written decision, including findings and determinations, after the conclusion of the hearing. Such decision shall include the findings of fact and conclusions of law which the presiding officer relied upon in determining whether a person is liable under this chapter. The presiding officer shall promptly send to each party to the hearing a copy of such decision and a statement describing the right of any person determined to be liable under section 3802 of this Title to appeal the decision of the presiding officer to the authority head under paragraph (2) of subsection (i).

(i) (1) Except as provided in paragraph (2) of this subsection and section 3805 of this Title, the decision, including the findings and determinations, of the presiding officer issued under subsection (h) of this section are final.

(2) (A) (i) Except as provided in clause (ii) of this subparagraph, within 30 days after the presiding officer issues a decision under subsection (h) of this section, any person determined in such decision to be liable under section 3802 of this Title may appeal such decision to the authority head.

(ii) If, within the 30-day period described in clause (i) of this subparagraph, a person determined to be liable under this chapter requests the authority head for an extension of such 30-day period to file an appeal of a decision issued by the presiding officer under subsection (h) of this section, the authority head extend such period if such person demonstrates good cause for such extension.

(B) Any authority head reviewing under this section the decision, findings, and determinations of a presiding officer shall not consider any objection that was not raised in the hearing conducted pursuant to subsection (f) of this section unless a demonstration is made of extraordinary circumstances causing the failure to raise the objection. If any party demonstrates to the satisfaction of the authority head that additional evidence not presented at such hearing is material and that there were reasonable grounds for the failure to present such evidence at such hearing, the authority head shall remand the matter to the presiding officer for consideration of such additional evidence.

(C) The authority head may affirm, reduce, reverse, compromise, remand, or settle any penalty or assessment determined by the presiding officer pursuant to this section. The authority head shall promptly send to each party to the appeal a copy of the decision of the authority head and a statement describing the right of any person determined to be liable under section 3802 of this Title to judicial review under section 3805 of this Title.

(j) The reviewing official has the exclusive authority to compromise or settle any allegations of liability under section 3802 of this Title against a person without the consent of the presiding officer at any time after the date on which the reviewing official is permitted to refer allegations of liability to a presiding officer under

subsection (b) of this section and prior to the date on which the presiding officer issues a decision under subsection (h) of this section. Any such compromise or settlement shall be in writing.

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31 U.S.C. § 3804 – Subpoena Authority

(a) For the purposes of an investigation under section 3803(a)(1) of this Title, an investigating official is authorized to require by subpoena the production of all information, documents, reports, answers, records, accounts, papers, and data not otherwise reasonably available to the authority.

(b) For the purposes of conducting a hearing under section 3803(f) of this Title, a presiding officer is authorized –

(1) to administer oaths or affirmations; and

(2) to require by subpoena the attendance and testimony of witnesses and the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence which the presiding officer considers relevant and material to the hearing.

(c) In the case of contumacy or refusal to obey a subpoena issued pursuant to subsection (a) or (b) of this section, the district courts of the United States shall have jurisdiction to issue an appropriate order for the enforcement of any such subpoena. Any failure to obey such order of the court is punishable by such court as contempt. In any case in which an authority seeks the enforcement of a subpoena issued pursuant to subsection (a) or (b) of this section, the authority shall request the Attorney General to petition any district court in which a hearing under this chapter is being

conducted, or in which the person receiving the subpoena resides or conducts business, to issue such an order.

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31 U.S.C. § 3805 – Judicial Review

(a) (1) A determination by a reviewing official under section 3803 of this Title shall be final and shall not be subject to judicial review.

(2) Unless a petition is filed under this section, a determination under section 3803 of this Title that a person is liable under section 3802 of this Title shall be final and shall not be subject to judicial review.

(b) (1) (A) Any person who has been determined to be liable under section 3802 of this Title pursuant to section 3803 of this Title may obtain review of such determination in –

(i) the United States district court for the district in which such person resides or transacts business;

(ii) the United States district court for the district in which the claim or statement upon which the determination of liability is based was made, presented, or submitted; or

(iii) the United States District Court for the District of Columbia.

(B) Such review may be obtained by filing in any such court a written petition that such determination be modified or set aside. Such petition shall be filed –

(i) only after such person has exhausted all administrative remedies under this chapter; and

(ii) within 60 days after the date on which the authority head sends such person a copy of the decision of such authority head under section 3803(i)(2) of this Title.

(2) The clerk of the court shall transmit a copy of a petition filed under paragraph (1) of this subsection to the authority and to the Attorney General. Upon receipt of the copy of such petition, the authority shall transmit to the Attorney General the record in the proceeding resulting in the determination of liability under section 3802 of this Title. Except as otherwise provided in this section, the district courts of the United States shall have jurisdiction to review the decision, findings, and determinations in issue and to affirm, modify, remand for further consideration, or set aside, in whole or in part, the decision, findings, and determinations of the authority, and to enforce such decision, findings, and determinations to the extent that such decision, findings, and determinations are affirmed or modified.

(c) The decisions, findings, and determinations of the authority with respect to questions of fact shall be final and conclusive, and shall not be set aside unless such decisions, findings, and determinations are found by the court to be unsupported by substantial evidence. In concluding whether the decisions, findings, and determinations of an authority are unsupported by substantial evidence, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

(d) Any district court reviewing under this section the decision, findings, and determinations of an authority shall not consider any objection that was not raised in the hearing conducted pursuant to section 3803(f) of this Title unless a demonstration is made of extraordinary circumstances causing the failure to raise the objection. If any party demonstrates to the satisfaction of the court that additional evidence not presented at such hearing is material and that there were reasonable grounds for the failure to present such evidence at such hearing, the court shall remand the matter to the authority for consideration of such additional evidence.

(e) Upon a final determination by the district court that a person is liable under section 3802 of this Title, the court shall enter a final judgment for the appropriate amount in favor of the United States.

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31 U.S.C. § 3806 – Collection of Civil Penalties and Assessments

(a) The Attorney General shall be responsible for judicial enforcement of any civil penalty or assessment imposed pursuant to the provisions of this chapter.

(b) Any penalty or assessment imposed in a determination which has become final pursuant to this chapter may be recovered in a civil action brought by the Attorney General. In any such action, no matter that was raised or that could have been raised in a hearing conducted under section 3803(f) of this Title or pursuant to judicial review under section 3805 of this title may be raised as a defense, and the determination of liability and the determination of amounts of penalties and assessments shall not be subject to review.

(c) The district courts of the United States shall have jurisdiction of any action commenced by the United States under subsection (b) of this section.

(d) Any action under subsection (b) of this section may, without regard to venue requirements, be joined and consolidated with or asserted as a counterclaim, crossclaim, or setoff by the United States in any other civil action which includes as parties the United States and the person against whom such action may be brought.

(e) The United States Claims Court shall have jurisdiction of any action under subsection (b) of this section to recover any penalty or assessment if the cause of action is asserted by the United States as a counterclaim in a matter pending in such court.

(f) The Attorney General shall have exclusive authority to compromise or settle any penalty or assessment the determination of which is the subject of a pending petition pursuant to section 3805 of this Title or a pending action to recover such penalty or assessment pursuant to this section.

(g) (1) Except as provided in paragraph (2) of this subsection, any amount of penalty or assessment collected under this chapter shall be deposited as miscellaneous receipts in the Treasury of the United States.

(2) (A) Any amount of a penalty or assessment imposed by the United States Postal Service under this chapter shall be deposited in the Postal Service Fund established by section 2003 of Title 39.

(B) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with

old age and survivors benefits under Title II of the Social Security Act shall be deposited in the Federal Old-Age and Survivors Insurance Trust Fund.

(C) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with disability benefits under Title II of the Social Security Act shall be deposited in the Federal Disability Insurance Trust Fund.

(D) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with benefits under part A of Title XVIII of the Social Security Act shall be deposited in the Federal Hospital Insurance Trust Fund.

(E) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with benefits under part B of Title XVIII of the Social Security Act shall be deposited in the Federal Supplementary Medical Insurance Trust Fund

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31 U.S.C. § 3807 – Right to Administrative Offset

(a) The amount of any penalty or assessment which has become final under section 3803 of this Title, or for which a judgment has been entered under section

3805(e) or 3806 of this Title, or any amount agreed upon in a settlement or compromise under section 3803(j) or 3806(f) of this Title, may be collected by administrative offset under section 3716 of this Title, except that an administrative offset may not be made under this subsection against a refund of an overpayment of Federal taxes, then or later owing by the United States to the person liable for such penalty or assessment.

(b) All amounts collected pursuant to this section shall be remitted to the Secretary of the Treasury for deposit in accordance with section 3806(g) of this Title.

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31 U.S.C. § 3808 – Limitations

(a) A hearing under section 3803(d)(2) of this Title with respect to a claim or statement shall be commenced within 6 years after the date on which such claim or statement is made, presented, or submitted.

(b) A civil action to recover a penalty or assessment under section 3806 of this Title shall be commenced within 3 years after the date on which the determination of liability for such penalty or assessment becomes final.

(c) If at any time during the course of proceedings brought pursuant to this chapter the authority head receives or discovers any specific information regarding bribery, gratuities, conflict of interest, or other corruption or similar activity in relation to a false claim or statement, the authority head shall immediately report such information to the Attorney General, and in the case of an authority in which an Office of Inspector General is established by the

Inspector General Act of 1978 or by any other Federal law, to the Inspector General of that authority.

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31 U.S.C. § 3809 – Regulations

Within 180 days after the date of enactment of this chapter, each authority head shall promulgate rules and regulations necessary to implement the provisions of this chapter. Such rules and regulations shall –

(1) ensure that investigating officials and reviewing officials are not responsible for conducting the hearing required in section 3803(f) of this Title, making the determinations required by subsections (f) and (h) of section 3803 of this Title, or making collections under section 3806 of this Title; and

(2) require a reviewing official to include in any notice required by section 3803(a)(2) of this Title a statement which specifies that the reviewing official has determined that there is a reasonable prospect of collecting, from a person with respect to whom the reviewing official is referring allegations of liability in such notice, the amount for which such person may be liable.

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31 U.S.C. § 3810 – Repealed

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31 U.S.C. § 3811 – Effect On Other Law

(a) This chapter does not diminish the responsibility of any agency to comply with the provisions of chapter 35 of Title 44.

(b) This chapter does not supersede the provisions of section 3512 of Title 44.

(c) For purposes of this section, the term "agency" has the same meaning as in section 3502(1) of Title 44.

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31 U.S.C. § 3812 – Prohibition Against Delegation

Any function, duty, or responsibility which this chapter specifies be carried out by the Attorney General or an Assistant Attorney General designated by the Attorney General, shall not be delegated to, or carried out by, any other officer or employee of the Department of Justice.

Relevant Excerpts from the Dictionary Act

1 U.S.C. § 1 – Dictionary Act

In determining the meaning of any Act of Congress, unless the context indicates otherwise –

words importing the singular include and apply to several persons, parties, or things;

words importing the plural include the singular;

words importing the masculine gender include the feminine as well;

words used in the present tense include the future as well as the present;

the words "insane" and "insane person" and "lunatic" shall include every idiot, lunatic, insane person, and person non compos mentis;

the words "person" and "whoever" include corporations, companies, associations, firms, partnerships, societies, and joint stock companies, as well as individuals;

"officer" includes any person authorized by law to perform the duties of the office;

"signature" or "subscription" includes a mark when the person making the same intended it as such;

"oath" includes affirmation, and "sworn" includes affirmed;

"writing" includes printing and typewriting and reproductions of visual symbols by photographing, multigraphing, mimeographing, manifolding, or otherwise.

Regulatory Provisions

The regulations covering payment for Part B medical and other health services for physicians and other practioners states in relevant part:

42 C.F.R. § 414.46 – Additional rules for payment of anesthesia services:

(a) Definitions. For purposes of this section, the following definitions apply:

(1) Base unit means the value for each anesthesia code that reflects all activities other than anesthesia time. These activities include usual preoperative and postoperative visits, the administration of fluids and blood incident to anesthesia care, and monitoring services.

(2) Anesthesia practitioner, for the purpose of anesthesia time, means a physician who performs the anesthesia service alone, a CRNA who is not medically directed who performs the anesthesia service alone, or a medically directed CRNA.

(3) Anesthesia time means the time during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the beneficiary, that is, when the beneficiary may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of anesthesia time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

(b) Determinations of payment amount – Basic rule. For anesthesia services performed, medically directed, or medically supervised by a physician, the carrier pays the lesser of the actual charge or the anesthesia fee schedule amount.

(1) The carrier bases the fee schedule amount for an anesthesia service on the product of the sum of allowable base and time units and an anesthesia-specific CF. The carrier calculates the time units

from the anesthesia time reported by the anesthesia practitioner for the anesthesia procedure. The physician who fulfills the conditions for medical direction in § 415.110 (Conditions for payment: Anesthesiology services) reports the same anesthesia time as the medically-directed CRNA.

(2) CMS furnishes the carrier with the base units for each anesthesia procedure code. The base units are derived from the 1988 American Society of Anesthesiologists' Relative Value Guide except that the number of base units recognized for anesthesia services furnished during cataract or iridectomy surgery is four units.

(3) Modifier units are not allowed. Modifier units include additional units charged by a physician or a CRNA for patient health status, risk, age, or unusual circumstances.

(c) Physician personally performs the anesthesia procedure.

(1) CMS considers an anesthesia service to be personally performed under any of the following circumstances:

(i) The physician performs the entire anesthesia service alone.

(ii) The physician establishes an attending physician relationship in one or two concurrent cases involving an intern or resident and the service was furnished before January 1, 1994.

(iii) The physician establishes an attending physician relationship in one case involving an intern or resident and the service was furnished on or after January 1, 1994 but prior to January 1, 1996. For services on or after

January 1, 1996, the physician must be the teaching physician as defined in §§ 415.170 through 415.184 of this chapter.

(iv) The physician and the CRNA or AA are involved in a single case and the services of each are found to be medically necessary.

(v) The physician is continuously involved in a single case involving a student nurse anesthetist.

(vi) The physician is continuously involved in a single case involving a CRNA or AA and the service was furnished prior to January 1, 1998.

(2) CMS determines the fee schedule amount for an anesthesia service personally performed by a physician on the basis of an anesthesia-specific fee schedule CF and unreduced base units and anesthesia time units. One anesthesia time unit is equivalent to 15 minutes of anesthesia time, and fractions of a 15-minute period are recognized as fractions of an anesthesia time unit.

(d) Anesthesia services medically directed by a physician.

(1) CMS considers an anesthesia service to be medically directed by a physician if:

(i) The physician performs the activities described in § 415.110 of this chapter.

(ii) The physician directs qualified individuals involved in two, three, or four concurrent cases.

(iii) Medical direction can occur for a single case furnished on or after January 1, 1998 if the physician performs the

activities described in § 415.110 of this chapter and medically directs a single CRNA or AA.

(2) The rules for medical direction differ for certain time periods depending on the nature of the qualified individual who is directed by the physician. If more than two procedures are directed on or after January 1, 1994, the qualified individuals could be AAs, CRNAs, interns, or residents. The medical direction rules apply to student nurse anesthetists only if the physician directs two concurrent cases, each of which involves a student nurse anesthetist or the physician directs one case involving a student nurse anesthetist and the other involving a CRNA, AA, intern, or resident.

(3) Payment for medical direction is based on a specific percentage of the payment allowance recognized for the anesthesia service personally performed by a physician alone. The following percentages apply for the years specified:

(i) CY 1994 – 60 percent of the payment allowance for personally performed procedures.

(ii) CY 1995 – 57.5 percent of the payment allowance for personally performed services.

(iii) CY 1996 – 55 percent of the payment allowance for personally performed services.

(iv) CY 1997 – 52.5 percent of the payment allowance for personally performed services.

(v) CY 1998 and thereafter – 50 percent of thepayment allowance for personally performed services.

Regulatory Provisions - Repealed

42 C.F.R. § 414.451 (1992) Basic methodology for calculating anesthetist fee schedule.

(a) Fee schedules. HCFA establishes separate State-level fee schedules for –

(1) Anesthetists whose services are medically-directed; and

(2) Anesthetists whose services are not medically-directed.

(b) Calculation of conversion factors for anesthetists who are medically directed.

(1) Hospital-employed anesthetists. State-specific conversion factors for medically-directed hospital employed anesthetists are computed from the 1987 American Association of Nurse Anesthetists annual membership survey, as follows:

(i) An average cost per case is computed by dividing the total reported State salaries of full and part-time medically-directed hospital-employed anesthetists by the total reported anesthetics administered by the anesthetists.

(ii) A base conversion factor is computed by dividing the average cost per case by the estimated national average of base and time units for an anesthesia case involving a

hospital-employed medically-directed anesthetist.

(iii) The conversion factor is adjusted to reflect an allowance that approximates fringe benefits and allowable hospital overhead associated with anesthetists' services.

(iv) The 1987 conversion factor is updated by an inflation factor through 1989.

(v) The conversion factor is increased to include a State specific amount for malpractice expense. The resultant amounts are considered to be State-specific conversion factors for medically-directed hospital-employed anesthetists.

(2) Physician-employed anesthetists. State specific conversion factors for medically-directed physician-employed anesthetists are computed as follows:

(i) The 1989 Statewide locality prevailing charge conversion factor for anesthesia services of participating physicians, as adjusted by the MEI, is multiplied by the average time per anesthesia case involving a medically directed physician-employed anesthetist, and divided by 30 minutes. (If there are multiple localities within a State or more than one carrier serves a State, a single, Statewide weighed average participating physician prevailing charge is applied.)

(ii) The resulting amount is divided by the average number of base and time units per anesthesia case involving a physician who medically directs and employs the CRNA.

(3) Calculation of medically-directed conversion factors. The applicable State-specific conversion factors for anesthetists who are medically directed are based on a blend of 58 percent of the hospital-employed conversion factor and 42 percent of the physician-employed conversion factor calculated under paragraphs (b)(1) and (b)(2) of this section, respectively.

(c) Calculation of conversion factors for anesthetists who are not medically directed. The State-specific conversion factors for anesthetists who are not medically directed are computed under the procedures in paragraph (b)(1) of this section except that;

(1) The total reported State salaries of full and part-time nonmedically-directed anesthetists and the total reported anesthetics administered by these anesthetists are used to compute an average cost per case; and

(2) A base conversion factor is computed by dividing the average cost per case by the estimated national average number of base and time units for an anesthesia case involving a nonmedically-directed anesthetist.

(d) Exceptions.–

(1) Insufficient State-level data for one conversion factor. If only one of the State-level conversion factors can be calculated, the other conversion factor is calculated based on that factor and on national statistics.

(2) Insufficient State-level data for both medically-directed and nonmedically-directed conversion factors. If neither the State-level medically-directed nor nonmedically-directed conversion factors can be calculated from State-specific data,

regional data are used to calculate both conversion factors.

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42 C.F.R. § 405.552 (1991) Conditions for payment of charges: Anesthesiology services.

(a) Services furnished directly or concurrently. The carrier will reimburse a physician for anesthesiology services furnished to patients in a provider on a reasonable charge basis only if the services meet the conditions for reasonable charge payment in § 405.550(b) and the following additional conditions are met:

(1) For each patient, the physician–

(i) Performs a pre-anesthetic examination and evaluation;

(ii) Prescribes the anesthesia plan;

(iii) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;

(iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;

(v) Monitors the course of anesthesia administration at frequent intervals;

(vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provides indicated postanesthesia care.

(2) The physician either performs the procedure directly, without the assistance of an anesthetist,

or directs no more than four anesthesia procedures concurrently, and does not perform any other services while he or she is directing the concurrent procedures.

(b) Supervision of more than four procedures concurrently. If the physician is involved in furnishing more than four procedures concurrently, or is performing other services while directing the concurrent procedures, the concurrent anesthesia services are physician services to the provider in which the procedures are performed. In such cases, the physician is not required to meet the criteria of paragraphs (a)(1)(iii) and (vii) of this section personally, but must ensure that a qualified individual performs any procedure in which the physician does not personally participate. In these cases, the intermediary will pay for the services under the rules in §§ 405.480 and 405.481 on reasonable cost payment for physician services to providers.

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS, GAYLE McKAY, LADONNA SCHWEER, JOHN OKONEK, BERNADINE OKONEK, ANNETTE ATCHISON, FRED BENJAMIN, BARY [sic] BARRY, FAYE LEATHERMAN, SUE MILBACH, SANDRA HENSCHKE, JUDITH A. SCHMIDT and GARY HAGEN,

Plaintiffs,

v.

UNITY HOSPITAL, MERCY HOSPITAL, WILLIAM MACNALLY, President and Chief Executive Officer of Unity

COMPLAINT AND DEMAND FOR JURY TRIAL

and Mercy Hospitals, ALLINA HEALTH SYSTEM CORP., MARK SPERRY, MDA, GARY BAGGENSTOSS, M.D., JOHN MURPHY, in his capacity as Vice President of Unity and Mercy Medical Centers, JAMES CUMMING, M.D., JOHN RYDBERG, M.D., MIDWEST ANESTHESIA, P.A., THELMA M. ALBAY, M.D., MINDA CASTILLEJOS, M.D., TERI HEIL, M.D., SANG HONG, M.D., TED JANOSSY, M.D., RAYMOND KLOEPPER II, M.D., JOHN MAGDSICK, M.D., THOMAS MAGGS, M.D., THOMAS POLTA, M.D., JOHN ROSEBERG, M.D., JAI SUH, M.D., JEFFREY YUE, M.D., MARK EGGEN, M.D., METROPOLITAN ANESTHESIA NETWORK, ALLEN TANK, THEODORE GRINDAL, ESQ., CRAIG JOHNSON, M.D., (both individually and in his capacity as President of the Minnesota Society of Anesthesiologists, ST. CLOUD HOSPITAL, JOHN FROBEMIUS, Chief Executive Officer of St. Cloud Hospital, LINDA CHIMIELEWSKY, Vice President Hospital Operations of

St. Cloud Hospital, ANESTHESIA ASSOCIATES OF ST. CLOUD LTD., GARY A BOEKE, M.D., PHILIP F. BOYLE, M.D., L. MICHAEL ESPELAND, M.D., ALAN D. ESPELIEN, M.D., PAUL J. HALVERSON, M.D., LANSE C. LANG, M.D., A. WADE McMILLAN, M.D., WILLIAM H. RICE, M.D., ALLAN REITZ, M.D. and ANNETTE E. ZWICK, M.D.,

Defendants.

Plaintiffs as and for their Complaint against defendants say:

1. This is an action for injunctive relief and damages arising out of a wide-spread conspiracy involving the instant defendants and MDAs at virtually every major general hospital in the Twin Cities area and throughout Minnesota whose objective is nothing less than the complete elimination of certified registered nurse anesthetists as low-cost competitors for the provision of anesthesia services in every market in which defendants and their co-conspirators operate. This action sounds in anti-trust under both Federal and state laws, including illegal boycotts, illegal tying arrangements, attempted monopolization and agreements in unreasonable restraint of trade. Defendants are also accused of multiple violations of the Minnesota Consumer Protection Act, Minn. Stat. § 3252 F.69, the Minnesota Deceptive Practices Act Minn. Stat. § 325.044, tortious interference with contractual and

prospective business relations, unfair competition, fraudulent billing in violation of various State and Federal Medicare statutes, participation in multiple terminations against public policy, breach of contract, violations of applicable whistleblowing statutes (Minn. Stat. 181.932), breach of covenant of good faith and fair dealing and civil conspiracy to commit the foregoing. Accordingly, this Court has jurisdiction over the causes of action alleged in the complaint pursuant to 15 U.S.C. §§ 15, 16 and 31 and Title 28 U.S.C. §§ 1331, 1332 and 1337, as well as supplemental jurisdiction pursuant to 28 U.S.C. § 1367.

2. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b) as it is the district where all defendants reside and in which the claim arose.

THE PARTIES

3. Plaintiff Minnesota Association of Nurse Anesthetists ("MANA") is an association formed for the purpose of preserving and advancing the profession of Certified Registered Nurse Anesthetists in Minnesota and, among other things, to engage in activities to promote and protect the legal rights of its members through, among other things, lobbying efforts, legal action and public relations activities.

4. Plaintiff Gayle McKay ("McKay") is the President of MANA and a member of its Board of Directors. She is also a certified registered nurse anesthetist who at all times pertinent hereto was duly licensed in the practice of administering anesthesia in the State of Minnesota. McKay is also currently certified by the American Association of Nurse Anesthetists and is a member of that association. McKay is a resident of Apple Valley, Minnesota.

5. Plaintiffs Ladonna Schweer ("Schweer"), John Okonek ("J. Okonek"), Bernadine Okonek ("B. Okonek"), Annette Atchison ("Atchison"), and Fred Benjamin ("Benjamin") are certified registered nurse anesthetists who at all times pertinent hereto were duly licensed in the practice of administering anesthesia in the State of Minnesota and associated with defendant Unity Hospital. Plaintiffs Bart Barry ("Barry"), Faye Leatherman ("Leatherman") and Sue Milbach ("Milbach") are certified registered nurse anesthetists who at all times pertinent hereto were duly licensed in the practice of administering anesthesia in the State of Minnesota and associated with defendant Mercy Hospital. The plaintiffs named in this paragraph will hereinafter be referred to as the "Unity/Mercy plaintiffs."

6. Plaintiffs Sandra Henschke ("Henschke") and Judith A. Schmidt ("Schmidt") are certified registered nurse anesthetists who at all times pertinent hereto were duly licensed in the practice of administering anesthesia in the State of Minnesota and associated with defendant St. Cloud Hospital. The plaintiffs named in this paragraph will hereinafter be referred to as the "St. Cloud plaintiffs."

7. Plaintiff Gary Hagen ("Hagen") is a certified registered nurse anesthetist who at all times pertinent hereto was duly licensed in the practice of administering anesthesia in the State of Minnesota and associated with St. Francis Hospital in Shakopee which is owned by defendant Allina and serviced by defendant MAN.

8. Defendant Allina Health System Corp. ("Allina") is a non-profit corporation and integrated health care system. Allina owns or operates 17 hospitals, 2 nursing homes and clinics in more than 40 locations throughout Minnesota and Western Wisconsin. Allina owns defendants

Unity and Mercy Hospital, Abbott Northwestern Hospital, United Hospital, Phillips Eye Institute and St. Francis Regional Medical Center in Shakopee. On information and belief, Allina is currently negotiating to purchase defendant St. Cloud Hospital.

9. Defendant Unity Hospital ("Unity") is a hospital operating at 550 Osborne Road in Fridley, Minnesota.

10. Defendant Mercy Hospital ("Mercy") is a hospital operating at 4050 Coon Rapids Boulevard in Coon Rapids, Minnesota.

11. Defendant William MacNally ("MacNally") is President and Chief Executive Officer of Unity and Mercy Hospitals.

12. Defendant John Murphy ("Murphy") is currently and was at all times pertinent hereto Vice President of Unity and Mercy Hospitals.

13. Defendant Midwest Anesthesia, P.A. ("MAPA") is a professional association which engages in, among other things, the provision of anesthesiological services to the defendants Unity and Mercy Hospitals.

14. Defendants Thelma M. Albay, M.D. ("Albay"), Gary Baggenstoss, M.D. ("Baggenstoss"), Minda Castillejos, M.D. ("Castillejos"), David Cumming, M.D. ("Cumming"), Teri Heil, M.D. ("Heil"), Sang Hong, M.D. ("Hong"), Ted Janossy, M.D. ("Janossy"), Raymond Kloepper, II, M.D. ("Kloepper"), John Magdsick, M.D. ("Magdsick"), Thomas Maggs, M.D. ("Maggs"), Thomas Polta, M.D. ("Polta"), John Roseberg, M.D. ("Roseberg"), Jai Suh, M.D. ("Suh"), Jeffrey Yue, M.D. (Yue"), Mark Eggen, M.D. ("Eggen"), Mark Sperry, M.D. ("Sperry") and John Rydberg, M.D. ("Rydberg") are medical doctors

specializing in anesthesia who maintained privileges at Unity and/or Mercy Hospitals at all times relevant to this Complaint and are members of MAPA (hereinafter collectively the "Unity/Mercy MDAs").

15. Defendant Metropolitan Anesthesia Network ("MAN") is a professional corporation which owns and controls MAPA, as well as other professional associations which anesthesiologists which privileges at Fairview Southdale Hospital, Fairview Ridges Hospital, several children's hospitals, and St. Francis Regional Medical Center.

16. Defendant Allen Tank ("Tank") at all times pertinent hereto was an employee of defendants MAPA and MAN and performed business management functions for these groups, as well as other anesthesiologist groups in the Twin Cities area. He is a resident of Minnesota.

17. The defendants named in paragraphs 1 through 16 shall be collectively referred to as the "Unity/Mercy defendants".

18. Defendant St. Cloud Hospital ("St. Cloud") is a hospital operating at 1406 6th Avenue N., St. Cloud, Minnesota 56303.

19. Defendants John Frobenius ("Frobenius") is the Chief Executive Officer of St. Cloud Hospital.

20. Defendant Linda Chimielewski ("Chimielewski") is the Vice President Hospital Operations of St. Cloud Hospital.

21. Defendant Anesthesia Associations of St. Cloud LTD ("AASC") is a professional partnership located at 816 West St. Germain St. Suite 403, St. Cloud, Minnesota

56301, whose anesthesiologist members maintain privileges at St. Cloud Hospital.

22. Defendants Gary A. Boeke, M.D. ("Boeke"), Philip F. Boyle, M.D. ("Boyle"), L. Michael Espeland, M.D. ("Espeland"), Alan D. Espelien, M.D. ("Espelien"), Paul J. Halverson, M.D. ("Halverson"), Lanse C. Lang, M.D. ("Lang") and A. Wade McMillan, M.D. ("McMillan"), William H. Rice, M.D. ("Rice"), Allan Reitz, M.D. ("Reitz") and Annette E. Zwick, M.D. ("Zwick") are medical doctors specializing in anesthesia who maintained privileges at St. Cloud Hospital at all times relevant to this Complaint and are members and/or employees of AASC.

23. Defendants in paragraphs 17 through 21 will hereinafter collectively be referred to as the "St. Cloud defendants."

24. Defendant Theodore Grindal, Esq. ("Grindal") is an attorney licensed to practice law in the State of Minnesota and was formerly a partner with the firm of Opperman, Heins & Paquin and is currently a partner with the Minneapolis law firm of Schatz Paquin Lockridge Grindal & Holstein.

25. Defendant Craig Johnson, M.D. ("Johnson") was at all times pertinent hereto President of the Minnesota Society of Anesthesiologists ("MSA") and maintains anesthesiology privileges at St. Cloud Hospital.

GENERAL ALLEGATIONS

26. This lawsuit stems from recent actions that have been taken and continue to be taken to dramatically alter the manner in which anesthesiological services are provided

to hospitals and patients in the Twin Cities market and every other market in the State of Minnesota.

27. Defendants have engaged in an illegal conspiracy to eliminate certified registered nurse anesthesiologists as competitors for provision of anesthesiological services wherever they compete with anesthesiologists. This conspiracy has already led to the termination of sixty-two (62) CRNAs previously employed by defendants Unity, Mercy and St. Cloud Hospitals, as well as the threatened imminant [sic] termination of all of the CRNAs employed by North Memorial Hospital, Abbott Northwestern Hospital, United Hospital, St. Johns Hospital, St. Joseph Hospital, Midway Hospital and several other prominent hospitals in the Twin Cities area and its outlying suburbs.

28. Following a blueprint proposed by defendant Grindal, defendant MDAs, all of whom are also members of the MSA, set out to conspire with members of the medical staff and administrative staff of defendant hospitals and other hospitals throughout the state to eliminate CRNAs who they saw as a lower cost provider of anesthesiological services, as competitors in the Twin Cities market and every other market where anesthesiologists compete with CRNAs for those services. A brief overview of how this conspiracy came about is necessary to understand defendants' position of market power in the Twin Cities' area.

HISTORY OF PROVISION OF ANESTHESIA IN THE UNITED STATES

29. Anesthesiology is a medical specialty which deals with the management of procedures for rendering a patient insensible to pain during surgical, obstetrical and

certain other medical procedures; the support of life functions under the stress of anesthetic and surgical manipulation; the clinical management of the patient unconscious for whatever cause; the management of problems in cardiac and respiratory resuscitation; the application of specific methods of inhalation therapy; and the clinical management of various fluid electrolyte and metabolic disturbances.

30. Certified registered nurse anesthetists are a group of health providers who are virtually unknown to the public at large, yet they administer more that 65% of the 26 million anesthetics given to patients each year in the United States. In 85% of rural hospitals, CRNAS are the *sole* anesthesia providers providing all aspects of anesthesia, including obstetrical, surgical and trauma stabilization services. While anesthesiologists, who are physicians, are often involved in the deliver of anesthesia services as part of an anesthesia care team, they are frequently absent from the operating room during the administration of anesthesia and for long periods of time during the surgery. It is the CRNA who, in most cases, performs the majority of the anesthesia procedures and who stays in the operating room with the patient throughout the operation.

31. Nurses, not doctors, were the first professional group to provide anesthesia services in the United States. Since the late 1800's, nurses have been providing anesthesia in response to surgeons' need for specially trained anesthetists.

32. Anesthesia was revolutionized in 1889 by Alice MaGaw, a nurse at St. Mary's Hospital in Rochester, Minnesota, which later became the Mayo Clinic.

33. During World War I, increased demand for anesthetists resulted in the training of nurses to provide anesthesia services both at home and abroad. Nurse anesthetists from the United States received foreign decorations for their contributions during World War I. In fact, it was not until after World War II that physicians became involved in anesthesia in any kind of wide-spread basis.

34. Since 1931, through its national association the American Association of Nurse Anesthetists, certified registered nurse anesthetists have produced educational and practice standards, implemented a certification process for nurse anesthetists and developed accreditation programs for nurse anesthesia education.

35. Currently, CRNAs work in every environment in which anesthesia is delivered, including traditional hospital, surgical suites, and obstetrical delivery rooms, offices of dentists, podiatrists, ophthalmologists and plastic surgeons, ambulatory surgical centers, the U.S. military, the U.S. public health services and veteran administration medical facilities.

36. No Federal or State statute requires that certified registered nurse anesthetists be supervised by an anesthesiologist, although some statutes provide that CRNAs must perform under the medical direction of a qualified physician. The Joint Commission on Accreditation of Health Care Organization also recommends that anesthesia performed by CRNAs be under the "supervision" of a physician. Minnesota law does not limit the scope of a CRNA's practice and does not require that CRNAs be medically directed. Since in practice there is

always a qualified physician in the form of a surgeon present at every operation, such requirements do not significantly restrict the CRNA's ability to provide anesthesia services in the absence of an anesthesiologist in virtually any setting.

37. The principal activity of most anesthesia providers who are in the clinical practice of medicine is in connection with the performance of surgery in a hospital. Ordinarily the patient about to undergo surgery does not chose his anesthesiology provider. That decision is usually made by the surgeon or assigned to the patient's case by the operating room supervisor or head of the anesthesiology department. It is not uncommon for a patient to have his first contact with the anesthesia provider just prior to being brought into the operating room for surgery.

38. While CRNAs are highly compensated because of the advanced medical services they perform, their compensation is roughly one-quarter of that which an MDA receives for performing roughly the same services.

39. Accordingly, historically since World War II, while anesthesia services have been provided in a variety of settings, including CRNAs only, anesthesiologists only and CRNAs under the direction of physicians or anesthesiologists, the majority of health care in the United States has been provided by way of anesthesia care teams. The anesthesia care teams are made up of a number of CRNAs who provide the majority of the anesthesia and related services under the direction of and/or supervision of an anesthesiologist. Such teams are the most cost effective method of providing anesthesia care since they utilize lower cost providers, CRNAs, and they minimize

the involvement of substantially higher cost providers, anesthesiologist MDAs.

IMPACT OF MEDICARE REGULATIONS ON THE PROVISION OF ANESTHESIOLOGICAL SERVICES

40. Since, on average, hospitals in the Twin Cities area that provide general surgical services provide approximately 30% of those services to Medicare related patients, Medicare strongly affects the way those hospitals operate.

41. Reimbursement for the provision of anesthesiological services has been treated uniquely by Medicare.

42. Prior to 1982, anesthesiologists and CRNAs did not compete with respect to Medicare reimbursements. This is because anesthesiologists billed under Part B of Medicare as independent health care practitioners whereas CRNAs' costs were billed by the hospital under Part A as part of the general costs of providing Medicare services.

43. Under pre-1982 Medicare regulations, anesthesiologists were permitted to supervise as many CRNAs as they wished and to bill for as many cases simultaneously as they wished. There was no limit on the number of concurrent cases for which an anesthesiologist could receive reimbursement for medically directing CRNAs, even though the direct participation of the MDA may have been minimal.

44. In 1982, in part as a result of what was believed to be wide-spread fraudulent billing practices by MDAs, Tax Equity And Fiscal Responsibility Act of 1982

("TEFRA") established conditions for anesthesiologists to fulfill in order to be paid for medically directing CRNAs. Those conditions were:

(a) Performs a pre-anesthesia examination and evaluation;

(b) Prescribes the anesthesia plan;

(c) Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence;

(d) Ensures that any procedure in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;

(e) Monitors the course of anesthesia administration at intervals;

(f) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provides indicated post anesthesia care.

45. These requirements were intended to ensure that anesthesiologists actually performed the work they were billing for. They in no way represented requirements based on any medical necessity or on the safety of the patient. This is clear from the fact that Medicare also provided for reimbursements of CRNAs whether medically directed or non-medically directed for performing all of the same procedures that anesthesiologists performed. Nevertheless, MDAs in the Twin Cities and elsewhere misrepresented these seven conditions of *reimbursement* as conditions of quality control. Accordingly, for the purpose of preserving their ability to be reimbursed and maximizing their income, and not for the safety of the patient, they began through their influence on hospital staffs to revise

hospital by-laws and amend procedures in the hospital to require their presence at particular times. As a result of this, CRNAs' ability to practice independently of MDAs, although not legally restricted by either Medicare or any other state or federal law, has been restricted by MDAs and the hospitals with which they associate.

46. Despite the enactment of the TEFRA requirements for reimbursement, MDAs in the Twin Cities continued to fraudulently bill and, in general, CRNAs continued to do the majority of the work involved with the provision of anesthesia services.

47. However, in or about 1983, Congress passed the Social Security Amendments of 1983 (Public Law 98-21) which created diagnosis-related groupings (DRGs). As a matter of inadvertence, CRNAs were left out of the DRGs, thereby impacting on hospitals' ability to bill for their services.

48. However, as a result of lobbying by CRNAs, in or about 1984, CRNAs obtained a pass-through provision in legislation which, as later amended, permitted hospitals to be reimbursed for CRNA costs on an interim basis until December 31, 1988.

49. Subsequently congress passed the Omnibus Budget Reconciliation Act of 1986 ("OBRA '86"), which established the ability for CRNAs to bill directly under Medicare Part B effective January 1, 1989.

50. With the passage of the OBRA '86 legislation, CRNAs became clearly defined as direct competitors with the defendant MDAs for the provision of anesthesia services to Medicare participants. In practice, since most CRNAs were employed by hospitals, they assigned their

independent billing rights to the hospital which billed Medicare on their behalf.

51. Another crucial change which was introduced in OBRA 86 was a change in the methodology for payment of anesthesiologists and nurse anesthetists. 42 C.F.R. 414.450 provided that, where an anesthesiologist was engaged in a single procedure and was not involved in any other concurrent cases, that, in most cases, the anesthesiologist would be paid 100% of the costs of the procedure regardless of whether any nurse anesthetist was involved. Thus, in such cases often referred to as "one-on-ones," the anesthesiologists may be paid for 100% of the work even if the CRNA performs the work. In contrast, if an anesthesiologist is involved in two or more concurrent cases, he will receive only a portion of the allocated cost of the procedure and the other portion will be paid to the CRNA. This change was crucial because it permitted an MDA, by fraudulent billing concurrent cases as "one-on-one," to deprive the CRNA and, therefore, the hospital (which employed the CRNA) of the ability to be compensated for the services actually performed by the CRNA while the MDA was out of the room supervising other cases.

52. Since 1989, under the current Medicare regulations as recently amended, CRNAs compete directly with anesthesiologists for payments from Medicare. Two bills are generated for every procedure in which anesthetists and anesthesiologists are involved. As a result of this, the widespread fraudulent billing practices of the anesthesiologists have become more apparent since Medicare, and other third party payers who have followed Medicare's lead, are receiving two bills for the same services.

53. Thus, the Medicare provisions, while intended to prevent fraudulent practices by anesthesiologists, have instead actually empowered anesthesiologists to limit CRNA practice and resulted in increased fraudulent billing by anesthesiologists in order to maximize their compensation.

ANESTHESIOLOGISTS IN THE TWIN CITIES MARKET HAVE AND EXERCISE MARKET POWER

54. Anesthesiologists, including defendant MDAs, have at all pertinent times to this Complaint possessed and exercised market power in the Twin Cities market. Evidence of this market power includes, but is not limited to, the following:

(a) On information and belief, the annual average income of MDAs in the Twin Cities area substantially exceeds that of MDAs in virtually every other state even though the annual average cost of health care in Minnesota is below the national average.

(b) On information and belief, average annual incomes for MDAs in the Twin Cities area exceeds $400,000.

(c) Nine anesthesia groups control over 85% of the market for anesthesiological services by MDAs.

(d) For the past ten (10) years, there has been virtually no competition among MDAs for the provision of anesthesiological services at major hospitals in the Twin Cities. Despite the fact that MDAs, including defendants, did not, prior to 1990, have exclusive agreements to provide anesthesiological services to Twin Cities hospitals, virtually no competitive bidding with respect

to such services has occurred in the past ten (10) years.

55. On information and belief, despite their relatively higher incomes, Minnesota MDAs spend far less time in the hospital than virtually any other medical doctor, including general surgeons.

56. The MDAs have created barriers to entry into the Twin Cities market which include the following:

(1) MDA's through their Association have misrepresented TEFRA requirements for reimbursement as quality of care requirements which are medically necessary for each operation thereby limiting CRNA's ability to practice independently;

(2) MDAs have engaged in conspiracies to deny CRNAs clinical privileges by amending hospital by-laws, downgrading CRNAs status as health care providers at the hospitals and other restrictive practices;

(3) The MDAs, through their national and state societies, have also initiated restrictive guidelines which restrict CRNAs from practicing regional anesthesia and performing other anesthesia services.

57. In addition to the above barriers to entry, MDAs possess market power through their status. MDAs sit on controlling boards of many of the Twin Cities hospitals. In addition, they exercise strong influence over the medical staffs of those hospitals as well as over the management of many health care organizations in the Twin Cities market.

THE CONSPIRACY IN THE TWIN CITY AREA

58. As will be detailed elsewhere in this Complaint, as a result of the MDAs' market power, defendants have engineered the termination of every CRNA employed by defendants Unity and Mercy and St. Cloud Hospitals, as well as the imminent termination of every CRNA employed at Abbott Northwestern Hospital. Virtually every other major hospital in the Twin Cities area is currently, as the result of defendants' efforts and the conspiracy in which the defendants are engaged, considering plans to terminate all of their CRNA employees. If these plans come to fruition, virtually every CRNA employed by a hospital in the Twin Cities area and throughout Minnesota will be terminated from his or her job.

59. Because of the dramatic changes in the health care market, including those in Medicare and other medical services' reimbursement policies, as well as the declining census in Minnesota and the changing health care market, MDAs, including defendants, have recognized that anesthesia services connected with surgeries, as well as the demand for anesthesia services in general have been and will continue to be declining. As a result, in a free market the demand for anesthesiologists and the potential price of anesthesiological services would also in all likelihood decline.

60. With the foregoing in mind, the defendants and their co-conspirators have set out to monopolize completely the market for anesthesia services in the Twin Cities area and to eliminate CRNAs as low cost competitors in those markets.

61. In furtherance of this conspiracy, defendant Grindal prepared a mass mailing of a letter in or about

October 28, 1992, which, while superficially represented itself to be general advice to anesthesiologists, was in fact a blueprint for the elimination of CRNAs in the Twin Cities area and throughout Minnesota. In particular, the letter informed MDAs that by raising "quality of care," "scheduling" and "staffing" issues, they might exclude and limit CRNAs ability to practice and compete and might compel hospitals to terminate their CRNA employees.

62. In addition to this mass mailing, on information and belief defendant Grindal attended meetings and provided anesthesiologists, including defendant anesthesiologists, with memoranda suggesting a similar blueprint. On information and belief, these memoranda and letters were provided to the hospitals, including defendant hospitals, in connection with the conspiracy to compel those hospitals to terminate CRNAs.

63. Defendant Grindal's letter, memorandum and oral statements were materially inaccurate in a number of respects and implied that the changes in the Medicare law would render CRNAs economically unviable for hospitals. In fact, the reverse was the case.

64. On or about January 8, 1993, attorneys representing the American Association of Nurse Anesthetists sent a letter to defendant Grindal demanding that he retract his inaccurate statements. However, he has refused to do so.

65. Pursuant to the Grindal blueprint, between October 1992 and the date of this complaint, defendant MDAs and their co-conspirators have engaged in numerous acts of misconduct with the intent and effect of eliminating CRNAs in the Twin Cities in general, and plaintiff CRNAs in particular, from competing with them as lower

cost and, therefore, more cost-effective anesthesia providers. The acts which defendants and their co-conspirators have engaged in include the following:

(a) Changing hospital by-laws to downgrade or restrict CRNAs' ability to practice.

(b) Changing credentialing processes to downgrade or restrict CRNAs' ability to practice.

(c) Changing hospital policies and procedures to limit CRNAs' ability to practice, including:

(1) restricting CRNAs' ability to perform certain procedures including the induction of anesthesia and regionals [sic] anesthesia;

(2) requiring CRNAs to keep patients asleep on the operating table with no medical necessity to do so in order to permit the anesthesiologist to return for the waking up of the patient;

(d) misrepresenting the law concerning CRNAs' legal ability to and competence to provide anesthesiological services;

(e) sending out inaccurate and misleading documents which disparage CRNAs and their abilities to practice anesthesia.

(f) limiting student CRNAs from performing routine anesthesia procedures necessary to obtain certification.

66. In addition to the foregoing and in combination therewith, the defendant anesthesiology groups and their co-conspirators have engaged in a wide-spread practice of fraudulent billing of anesthesia services in violation of Minn. Stat. 147 § 147.091 and Federal statutes, including § 1128(a)(1)(A). Such violations include, but are not

limited to, billing for services that they did not render, billing for operations at which they were not present and inaccurately designating operations as one-on-one for Medicare purposes.

67. In particular, defendants engaged in the following acts in furtherance of their combination conspiracy and agreement:

(a) Defendants MAN and MAPA engaged in fraudulent billing practices as described in the foregoing paragraphs with the intent that Medicare and other third party payors would refuse to reimburse CRNAs (and hospitals) for work performed by those CRNAs as a result of the fact that the anesthesiologists had already billed them for those services. Defendants succeeded in this goal and as a result Medicare and other third party payors rejected claims by the hospital to be reimbursed for CRNA services in connection with operations at which the CRNAs actually performed the work.

(b) In particular, in or about late 1991, Travelers Insurance Company performed an audit at Unity and Mercy Hospitals which revealed, among other things, that substantial numbers of anesthesia cases were being double billed, *i.e.,* that a CRNA and anesthesiologist were billing for the same services.

(c) As a result of this audit, a meeting took place between certain CRNAs at Unity/Mercy hospitals and Judy Haviland, Vice President of Unity/Mercy hospitals. At that meeting, CRNAs were informed of Traveler's audit result and were advised that Travelers had sent the hospital a letter instructing it not to bill for CRNA services where the anesthesiologist had separately billed.

CRNAs, at that meeting, advised the hospital that it was defendants MAN and MAPS who were, in fact, fraudulently billing Travelers, Medicare and others for work that they, in fact, never performed.

(d) Shortly thereafter a meeting was held with representatives of the defendant MDAs and certain Unity/Mercy CRNAs. At that meeting one of the MDAs remarked in words or substance that the CRNAs were getting what they deserved because they had sought (and obtained in OBRA '86), the legal authority to bill separately. As that MDA put it, the CRNAs had "stuck their heads out of the foxholes and they were now getting their heads shot off." The meeting was adjourned with the understanding that further action would be taken.

(e) Shortly after that meeting, however, CRNAs were advised that they would not be permitted to attend any further meetings regarding this subject with the MDAs.

(f) Subsequent to the above meeting, Judy Haviland was succeeded by defendant, John Murphy, who met with certain Unity/Mercy CRNAs who provided Murphy with documentary evidence in the form of anesthesia records which demonstrated that MDAs were fraudulently billing cases. Murphy advised those CRNAs that the President would take the matter to the Board. He also arranged a meeting with Healthspan's attorney to discuss how such fraudulent billing could be proved.

(g) After the meeting with Murphy, CRNAs were advised that Murphy had taken the matter to defendant MacNally, the Chief Executive Officer, and that MacNally had in turn presented the

issue to the Board of Directors. However, the CRNAs were not advised of the results of those meetings.

(h) Some time in or about February 1993, while these discussions were ongoing, the Unity/Mercy CRNAs, were advised that Unity/Mercy hospitals were going to participate in something called "operations improvement" ("OI"). It was explained that the purpose of OI was to improve the efficiency of the delivery of health care services by Unity/Mercy hospitals through the input of hospital employees. Over the next several months, CRNAs at Unity/Mercy engaged in extensive discussions, meetings and study to provide proposals to save money and reduce the cost of providing anesthesiological services at Unity/Mercy.

(i) Among the proposals developed by the CRNAs was a proposal which would save approximately a half a million in anesthesiology services. This proposal was presented to the hospital and nothing further was heard of it. However, on or about July 14, 1993, John Murphy met with the CRNA managers of Unity /Mercy and advised them in words or substance that the hospital had decided to "get out of the CRNA business." As a result, the CRNAs were informed the hospital intended to terminate every CRNA currently employed by the hospital and enter into an exclusive agreement with defendant MDAs to provide anesthesiological services. This was the first time that any CRNAs at Unity/Mercy were even aware that the hospital was discussing termination of CRNAs. Indeed, all of the discussions involving this subject were conducted secretly between Murphy and other hospital employees and defendant MDAs without disclosing them to the

CRNAs. At that same meeting, Murphy was asked whether he had considered the anti-trust implications of what the hospital and the MDAs were doing. Murphy responded that the matter had been considered with the hospital's attorneys.

(j) Sometime during this same time period, the hospital amended its by-laws to classify CRNAs as allied health professionals thereby precluding them from obtaining independent privileges at the hospital and further limiting their ability to practice independently of MDAs.

(k) On or about July 22, 1993, the Unity/Mercy CRNAs were notified that the hospital would terminate all of them effective December 31, 1993. During this same time frame, John Murphy stated that the termination of Unity/Mercy's CRNAs was just the beginning and that the same thing was going to happen at "every hospital". The Unity/Mercy CRNAs were also told that the hospital had agreed to an exclusive contract with defendant MAP and that the hospital would not deal either collectively or independently with the CRNAs. Shortly after this meeting one of the CRNAs, Fred Benjamin, went down to the Medical Staff secretary and asked for applications for hospital privileges and allied health privileges. Based upon advice from the hospital administration, the clerk refused to even give the CRNA an application. In short, CRNAs were advised that they were all to be terminated, that they had no say in the matter, that they had no ability to obtain privileges at the hospital and that the hospital refused to negotiate or deal with them independent of the defendant MDAs.

(l) During this same time period, one of the Unity/Mercy CRNAs attended a dinner and was informed by a member of the Board of Directors of Unity/Mercy hospital in words or substance that the CRNAs at Unity/Mercy were being terminated because of the MDA's fraudulent billing.

(m) Between July 1992 and December 1993, plaintiffs requested the right to negotiate with the hospital on a number of occasions and were categorically rejected. In or about December 1993, Unity/Mercy CRNAs were advised that they would not be terminated on December 31 because the hospital had not reached an agreement with the anesthesiologists. The CRNAs who had formed their own corporation again asked to bid to provide anesthesia services and were refused by the hospital.

(n) In or about October 1993, defendant Sperry stated to a number of Unity/Mercy CRNAs that the exclusive agreement with the hospital was for the purpose of obtaining power and control over the market for anesthesiological services. He stated in words or substance "as a group of anesthesiologists, we don't have much say and we could be replaced easily. But if we control all the anesthesia provided, we will have power." Sperry further indicated that the anesthesiologists did not intend to lose a single anesthesiologist or a single dollar of compensation as a result of the changes that were coming in the Minnesota market. On March 22, 1994, Unity/Mercy hospitals terminated all 48 CRNAs that were employed by the hospital.

(o) In furtherance of defendants' conspiracies, the CRNA manager and the individuals who had founded the CRNA corporation which had attempted to negotiate with the hospital were refused employment by the defendant MDAs.

(p) In order to compel CRNAs to subjugate themselves to the MDAs and to remove them as potential competitors to defendant MDAs, the hospital offered a severance policy which provided in pertinent part that CRNAs who refused employment with the MDAs would receive no severance. In contrast, CRNAs who accepted employment with the defendant MDAs were given 50% of their severance even though they would be employed. The clear intention of this agreement between the hospital and the MDAs was to compel and coerce the CRNAs to give up their independence and agree to be employed by defendant MDAs.

(q) Plaintiffs are informed and believe that the secret exclusive agreement between hospitals and defendant MDAs provides precisely for the amount of CRNAs to be hired and divides the profits made by the CRNAs between the defendant hospitals and the MDAs.

68. The defendants' conspiracy is not confined in any respect to defendant Unity and Mercy hospitals. Indeed, that conspiracy permeates the Twin Cities market for general surgical services and extends to other markets.

69. At St. Cloud Hospital, an outlying hospital, similar actions have led to the termination of another 18 CRNAs:

(a) Similar fraudulent billing practices occurred at St. Cloud. Defendant AASC billed for medically

directed operations as 1-1, thereby depriving the CRNAs of reimbursement from Medicare. The widespread nature of this practice reduced the economic value of the St. Cloud CRNAs to the Hospital. St. Cloud CRNAs challenged this practice. Shortly thereafter, in or about the summer of 1992, the operation improvement campaign was initiated at St. Cloud hospital. As at Unity and Mercy, St. Cloud CRNAs were excluded from the process and were not allowed to participate in aspects of the operation dealing with anesthesiology.

(b) In or about April of 1993, CRNAs were asked whether there would be a smooth transition if the CRNAs were terminated by the hospital.

(c) In July 1993, the hospital amended its by-laws to downgrade CRNA's status from associates to assistants. This action decreased the value of CRNA's to the hospital since it rendered them totally dependent on MDAs who were not hospital employees.

(d) Shortly thereafter, the CRNA credentialling process was changed to limit CRNAs' ability to practice certain procedures and further caused their dependence up MDAs.

(e) Sometime during this time frame, defendant Johnson, then President of the MSA, told the CRNA at St. Cloud that CRNAs' salaries were rising and MDAs' salaries were dropping. Accordingly, Johnson stated in substance that it was necessary to eliminate the CRNAs as competitors in order to stabilize and increase MDAs' salaries.

(f) On or about March 1, 1994, all St. Cloud CRNAs' were advised that they would be terminated on July 1, 1994. This position was revised while

negotiations continued between the MDAs and St. Cloud hospital. Subsequently, St. Cloud CRNAs were advised that they would be terminated on October 1, 1994. This date was later modified to November 1, 1994. Of the eighteen CRNAs terminated by the Hospital, only five were not offered employment by defendant AASC. Three of those five were former Presidents of plaintiff MANA.

70. As of this date, Abbott Northwestern, another Allina hospital in the Twin Cities market, has advised its CRNAs that it intends to eliminate all 46 of them imminently. Plaintiffs are informed and believe that the MDAs at Abbott Northwestern have engaged in similar anti-competitive conduct including limitation of student procedures, intimidation of CRNAs and informal limitation of CRNA procedures at that hospital. Following the Grindal blueprint, defendants have compelled the hospital to engage a study of CRNA anesthesia services as a smoke screen to disguise their illegal conspiracy to eliminate CRNAs for anti-competitive and retaliatory reasons.

71. As a result of defendants' conspiracy, similar studies have been initiated at Fairview Ridges Hospital, Fairview Southdale, St. Johns, St. Joseph's Hospital, University of Minnesota Hospital, United Hospital, North Memorial Medical Center, Fairview Riverside Medical Center, Midway Hospital and St. Paul Ramsey Hospital. The foregoing hospitals control over 80% of the Twin Cities market for general surgical services. If they were to terminate all of their CRNAs, it would have a devastating impact upon the market for anesthesia services in the Twin Cities area.

72. Furthermore, as a result of defendants' conspiracy, plaintiff CRNAs are precluded from simply moving to other hospitals to provide lower cost, cost-effective anesthesiological services. If defendants succeed in their conspiracy, the entire Twin Cities market and all of the outlying markets will be deprived of the ability to access the lower cost effective services that can be provided by CRNAs. Moreover, defendant MDAs and their co-conspirators shall exercise unmitigated control over the market for anesthesia services in the Twin Cities area and in every other significant market in Minnesota and, therefore, the price of those services.

73. At St. Francis Regional Medical Center in Shakopee, another Allina hospital serviced by MDAs from defendant MAN which is outside of the Twin Cities market, CRNAs have been threatened and intimidated. An attempt to terminate all CRNAs employed at the hospital was prevented only because the nurse's union stepped in.

74. In addition, to eliminate competitors currently competing in the market, defendant conspirators have taken steps to eliminate the supply of those competitors, i.e., the schools for certified registered nurse anesthetists. Recently, the medical director of Abbott Northwestern School, an anesthesiologist, sent a letter suggesting she would resign as medical director. A number of MDAs who previously were relied upon as lecturers have refused to give lectures at the School. In addition, MDAs in the various hospitals where the students receive clinical training are refusing to give those students the opportunity to perform the procedures which are necessary to graduate and obtain certification as CRNAs.

75. In concert with these activities, MDAs have been attempting to intimidate students in the various hospitals and to persuade them to leave the practice of nurse anesthesia and/or the Twin Cities area.

76. Finally, recent discussion of budgets for Abbott Northwestern indicate that the hospital may eliminate the school altogether within the next fiscal year.

77. Similar actions are occurring at Minneapolis School of Anesthesia.

78. Plaintiffs and defendants, including defendant hospitals, have received substantial revenue both from the Federal government in the form of Medicare and Medicaid payments and from private insurance companies and private third party payers, all of which are located out-of-state all of which funds flow across state lines in interstate commerce. In addition, plaintiffs and defendant physicians and hospitals utilize or prescribe substantial quantities of drugs, medications, surgical supplies, equipment and other products related to the provision of anesthesia which are manufactured out of state and shipped in interstate commerce. For these and other reasons stated herein, defendants' conduct alleged herein has occurred in interstate commerce and/or though local in nature has an effect on interstate commerce.

79. In summary, the defendants and their co-conspirators have been and continue to be engaged in a conspiracy combination and agreement to drive certified registered nurse anesthetists out of the competitive market for anesthesiological services in the Twin Cities area and, indeed, throughout Minnesota. Defendants have already been successful in eliminating CRNAs as competitors in three of the cities largest hospitals, Unity, Mercy

and St. Cloud. They are on the verge of eliminating CRNAs at several more hospitals, including Abbott Northwestern and North Memorial. Defendants and their co-conspirators have market power and are exercising that market power to obtain monopoly power.

COUNT ONE

80. Plaintiffs repeat and allege the allegations contained in paragraphs 1 through 78 as if the same were set forth herein at length.

81. The foregoing acts by defendants which were committed individually and collectively constitute an anti-competitive contract, combination, scheme, conspiracy, agreement and/or concerted action among two or more persons or distinct business entities.

82. Those persons and entities intended and/or did unreasonably harm and/or restrain competition and actually injured competition in violation of Sherman Anti-Trust Act 15 U.S.C. § 1.

COUNT TWO

83. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 81 if same were set forth herein at length.

84. The foregoing acts by defendants which were committed individually and collectively constitute, among other things, an anti-competitive contract, combination, scheme, conspiracy and agreement and/or concerted action among two or more persons or distinct business entities, by which those persons and entities intended to harm or

restrain competition and which actually injured competition in violation of Minnesota Statutes § 325D.53.

COUNT THREE

85. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 83 as if same were set forth herein at length.

86. The foregoing acts by the defendants which were committed individually and collectively constitute an agreement among competitors to refuse to deal with another competitor and/or an illegal boycott for anti-competitive purposes.

87. This boycott has had a direct anti-competitive effect on relevant markets, including the Twin Cities market, for provision of anesthesia services to hospitals and the Twin Cities market for the provision of anesthesia services to consumers and has and will substantially foreclose competition in those markets.

88. As a result of the acts of misconduct set forth above, defendants have committed a *per se* violation of Section 1 of the Sherman Anti-Trust Act.

89. Each of the defendants individually and all of the defendants jointly entered into and performed all of the aforesaid acts and activities in the furtherance of the contract combination scheme and conspiracy designed to injure plaintiffs and their business and property, and have accomplished their purpose.

90. The foregoing acts were performed by defendants individually and jointly with malice toward and/or reckless disregard for plaintiffs' rights.

COUNT FOUR

91. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 89 if same were set forth herein at length.

92. The foregoing acts of misconduct, including, without limitation, the wrongful termination of the Mercy Unity CRNAs by defendants associated with those Hospitals and the wrongful termination of the St. Cloud CRNAs by defendants associated with St. Cloud, constitute a conspiracy to monopolize and/or an intentional attempt to monopolize which has a dangerous probability of success and/or actual monopolization of the relevant markets, including the market for provision of anesthesiological services to hospitals and the Twin Cities market for the provision of anesthesiological services to consumers, all in violation of Section 2 of the Sherman Anti-Trust Act.

93. Plaintiffs have suffered damages as a result of defendants' misconduct.

COUNT FIVE

94. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 92 as if same were set forth herein at length.

95. The foregoing acts of misconduct by defendants constitute an illegal tying arrangement of two separate and distinct products, i.e., surgical services and anesthesiological services in violation of Sections 1, 2, 14, 15 and 26 of the Sherman Anti-Trust Act and the Clayton Anti-Trust Act. Defendants and their co-conspirators have market power in the tying market to coerce purchase of the tied product and defendants' conduct has and will foreclose a

substantial volume of commerce in the market for the tied product and/or has or will cause substantial anti-competitive effects in both the tied and tying markets.

96. Each of the defendants individually and all of the defendants jointly entered into and performed all of the aforesaid acts and activities in the furtherance of the contract combination scheme and conspiracy designed to injure plaintiffs and their business and property, and have accomplished their purpose.

97. Plaintiffs were injured in their business and/or property as a result of such tying arrangements.

98. The foregoing acts were performed by defendants individually and jointly with malice toward and/or reckless disregard for plaintiffs' rights.

COUNT SIX

99. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 97 as if same were set forth herein at length.

100. Unity, Mercy and St. Cloud hospitals and/or the other hospitals named herein constitute essential facilities which cannot be practically duplicated by would-be competitors.

101. It would be economically and technically unfeasible to replicate the hospitals and operating rooms controlled by defendants and denial of the use of such facilities inflicts a severe handicap on potential market entrants.

102. The foregoing acts of misconduct by defendants constitute an unreasonable denial to plaintiffs of essential facilities in violation of federal anti-trust law.

103. A denial of access to these essential facilities has and will substantially impact upon competition in the market for provision of anesthesia services to hospitals and to patients in the Twin Cities area.

COUNT SEVEN

104. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 102 as if same were set forth herein at length.

105. The foregoing acts of misconduct by defendants Grindal, Johnson, MAN, MAPA, AASC and the Unity/Mercy and St. Cloud MDAs constitute the act, use or employment of fraud, false pretense, false promise, misrepresentation, misleading statements or deceptive practices with the intent that others rely thereon in connection with the sale of services in violation of the Minnesota Consumer Fraud Act, Minn. Stat. 3325F.69.

106. Plaintiffs have suffered damages as a result of the actions referred to in paragraph 105 above.

107. The foregoing acts were performed by the above defendants individually and jointly with malice toward and/or reckless disregard for plaintiffs' right.

COUNT EIGHT

108. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 106 as if same were set forth herein at length.

109. Defendants Johnson, MAN, MAPA and AASC's acts of misconduct set forth in the foregoing paragraphs constitute deceptive trade practices in that defendants individually and collectively represented services in a deceptive manner and passed off services performed by CRNAs as services performed by MDAs, all in violation of Minn. Stat. 325D.44, *et seq.*, and defendants have disparaged the services and business of plaintiff CRNAs by spreading false and misleading representations of fact as set forth herein.

110. Plaintiffs have suffered damages as a result of the above defendants' actions.

111. The foregoing acts were performed by the above defendants individually and jointly with malice toward and/or reckless disregard for plaintiffs' rights.

COUNT NINE

112. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 112 as if same were set forth herein at length.

113. The foregoing acts of misconduct by defendants were committed with the intention to interfere with existing contractual and prospective business and economic relations of plaintiffs with third parties, including other hospitals, Medicare and defendant hospitals.

114. As a result of the above defendants' tortious interference with the contractual and prospective business and economic relations of plaintiffs, plaintiffs have suffered damage.

COUNT TEN

115. Plaintiffs repeat and reallage the allegations contained in paragraphs 1 through 113 as if same were set forth herein at length.

116. The foregoing acts of misconduct by defendants Johnson, MAN, MAPA, AASC, the Unity/Mercy MDAs and the St. Cloud MDAs constitute tortious conduct which interfered with plaintiffs' ability to compete with defendants and, therefore, constitute unfair competition under Minnesota law.

COUNT ELEVEN

117. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 115 as if same were set forth herein at length.

118. The foregoing acts of misconduct by the defendant hospitals constitute breach of the implied covenant of good faith and fair dealing contained in plaintiffs' employment agreements with defendant hospitals.

119. As a result of defendant hospitals' acts, plaintiffs have suffered damages.

COUNT TWELVE
(Against the Unity/Mercy Defendants)

120. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 118 as if same were set forth herein at length.

121. The Unity/Mercy defendants' acts of misconduct set forth in the foregoing paragraphs, including defendants' conspiracy to terminate the Unity/Mercy plaintiffs

as a result of those CRNA's complaints about defendant MDA's fraudulent billing practices constitutes prohibited action under the Minnesota Whistleblowing Statute, Minn. Stat. 181.932.

122. As a result of defendants' acts, the Unity/Mercy plaintiffs have suffered and will suffer damage.

COUNT THIRTEEN
(Against the St. Cloud Defendants)

123. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 121 as if same were set forth herein at length.

124. The St. Cloud defendants' acts of misconduct set forth in the foregoing paragraphs, including defendants' conspiracy to terminate the St. Cloud plaintiffs as a result of those CRNA's complaints about defendant MDA's fraudulent billing practices constitutes prohibited action under the Minnesota Whistleblowing Statute, Minn. Stat. 181.932.

125. As a result of defendants' acts, the St. Cloud plaintiffs have suffered and will suffer damage.

COUNT FOURTEEN

126. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 124 as if same were set forth herein at length.

127. The Unity/Mercy defendants' acts of misconduct set forth in the foregoing paragraphs, including defendants' conspiracy to terminate the Unity/Mercy CRNAs as a result of those CRNA's complaints about defendant

MDA's fraudulent billing practices constitutes wrongful termination in violation of public policy under state law.

128. As a result of defendants' acts, the Unity/Mercy plaintiffs have suffered and will suffer damage.

COUNT FIFTEEN

129. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 130 as if same were set forth herein at length.

130. The St. Cloud defendants' acts of misconduct set forth in the foregoing paragraphs, including defendants' conspiracy to terminate the St. Cloud CRNAs as a result of those CRNA's complaints about defendant MDA's fraudulent billing practices constitutes wrongful termination in violation of public policy under state law.

COUNT SIXTEEN
(Civil Conspiracy)

131. The foregoing acts described in Counts One through Sixteen were in aid of and part of a civil conspiracy between and among the defendants.

132. As a result of the above, each of the defendants is vicariously and independently liable for the damages caused by the actions of every other defendant in furtherance of defendants' civil conspiracy.

133. As a result of defendants' acts, plaintiffs have suffered damage.

WHEREFORE, plaintiffs jointly and severally demand judgment against defendants, jointly and severally, as follows:

A. A preliminary and permanent injunction enjoining defendants from further violations of the state and federal anti-trust laws and requiring defendants to eliminate all unlawful restrictions on the practice of plaintiffs and their profession.

B. An Order reinstating the Mercy/Unity plaintiffs as employees.

C. An Order reinstating the St. Cloud plaintiffs as employees.

D. A preliminary and permanent injunction enjoining defendants from taking any action, including termination of employment or reduction in pay or benefits, against any of the plaintiffs or any CRNAs or other persons as a result of their participation in or assistance of this action.

E. An Order requiring defendants to pay severance improperly withheld from plaintiffs.

F. Compensatory damages in an amount to be determined at trial.

G. Punitive damages as permitted by law.

H. Treble damages as provided by applicable law.

I. Interest, costs of suit and reasonable attorney's fees as provided by applicable law.

J. Awarding such other and further relief as the Court shall deem to be just and equitable.

2510 Minnesota
World Trade Center
30 East Seventh Street
St. Paul, MN 55101
(612) 227-7731

75 Livingston Avenue
Roseland, NJ 07068
(201) 535-1900

Dated: November 8, 1994

/s/ William S. Rosen
William S. Rosen (9349X)

STERN & GREENBERG

By: /s/ H J Stern
Herbert J. Stern
(3169)
David S. Stone

Attorneys for Plaintiffs

EXHIBIT B

12614091
NURSES FILE SUIT AGAINST 3 HOSPITALS NURSE ANESTHETISTS SAY CONSPIRACY ENDED JOBS
St. Paul Pioneer Press (ST) – THURSDAY, November 10, 1994
By: Judith Yates Borger, Staff Writer
Edition: Metro Final Section: Business Twin Cities Page: 1F
Word Count: 394

TEXT:
The Minnesota Association of Nurse Anesthetists charged in a lawsuit served Wednesday that Unity, Mercy and St. Cloud hospitals have conspired to form a "secret and exclusive agreement to divide profits" made through "fraudulent billing" between themselves and anesthesiologists.

In essence, the suit charges that anesthesiologists, who are doctors paid about four times as much as nurse anesthetists for performing roughly the same service, conspired with the hospitals to eliminate nurse anesthetists, who are lower-cost competitors. The defendants billed Medicare and third-party payers for services they did not render and billed for operations at which they were not present, the suit charges.

A spokeswoman from Allina Health System Corp., owner of Mercy in Coon Rapids and Unity in Fridley, declined to comment Wednesday because Allina had not yet been served with the suit. Other defendants are several Twin Cities anesthesiologists and Theodore Grindal, an attorney who, the complaint alleges, wrote the "blueprint" to eliminate the nurses. Grindal could not be reached for comment.

William S. Rosen, attorney for the nurses, declined to estimate how much money might be involved.

"I don't want to comment on that until discovery has been completed." he said. The first hearing on the suit is scheduled for Nov. 15.

In April, Unity, Mercy and St. Cloud hospitals told 62 nurse anesthetists that they would be laid off as employees and some of them rehired as contractors working for anesthesiologists. At the time, the hospitals said that Medicare wanted to pay for anesthesia services with just one fee, instead of two fees, one to the supervising anesthesiologist and one for the nurse anesthetist.

Nurses who refused employment with the anesthesiologists were offered no severance, according to the suit, while nurses who accepted employment were given 50 percent of their severance.

Nurse anesthetists are paid about $75,000 a year, according to the complaint. Anesthesiologists who contract with hospitals can earn as much as $400,000 a year, according to the complaint.

The suit charges that the "conspiracy" has led to threatened termination of all the nurse anesthetists in "several prominent hospitals in the Twin Cities and its outlying suburbs."

According to the complaint, nurse anesthetists administer more than 65 percent of the 26 million anesthetics given to patients in the United States each year. In 85 percent of rural hospitals, nurse anesthetists are the sole providers of anesthesia.

ST. CLOUD
Times
Friday, Nov. 11, 1994

Suit accuses 3 hospitals of conspiracy

St. Cloud Hospital named in court action as conspiring to get rid of nurse anesthetists

ST. PAUL – A group of Minnesota nurses has filed suit against three hospitals, including St. Cloud Hospital, charging they conspired with doctors to eliminate nurse anesthetists.

In a lawsuit filed Tuesday in federal court in St. Paul, the Minnesota Association of Nurse Anesthetists alleges St. Cloud Hospital, Unity Hospital in Fridley and Mercy Hospital in Coon Rapids conspired to form a "secret and exclusive agreement to divide profits" made through fraudulent billing between themselves and anesthesiologists.

In essence, the suit charges that anesthesiologists conspired with the hospitals to eliminate nurse anesthetists. Anesthesiologists are doctors, and they often are paid about four times as much as nurse anesthetists for performing roughly the same service.

The suit charges the "conspiracy" has led to threatened termination of all the nurse anesthetists in "several prominent hospitals in the Twin Cities and its outlying suburbs."

The suit charges the hospitals billed Medicare and third-party payers for services they did not render and billed for operations at which they were not present.

St. Cloud Hospital was served the legal papers Thursday, said Sue Mackert, hospital spokeswoman.

Last spring, Unity, Mercy and St. Cloud hospitals told 56 nurse anesthetists they would be laid off, and some of them would be rehired as contractors working for anesthesiologists. At the time, the hospitals said Medicare wanted to pay only one fee for anesthesia services. There used be two fees – one fee for the supervising anesthesiologist and one for the nurse anesthetist.

WHAT'S NEXT

There will be a hearing at 8:30 Tuesday at the Minneapolis federal courthouse. Marc Kessler, spokesman for the Minnesota Association of Nurse Anesthetists, said the plaintiffs will ask a judge to protect them from being penalized or disqualified by the defendants.

Nurses who refused employment with the anesthesiologists were offered no severance, according to the suit, while nurses who accepted employment were given 50 percent of their severance.

Twenty nurse anesthetists were laid off at St. Cloud Hospital last spring, Mackert said. Anesthesia Associates of St. Cloud, which contracts services with the hospital, hired 13 of them. The hospital was losing money because of changes in reimbursement for anesthesia services,

according to a hospital publication. The layoffs were a cost-effective move, it said.

Mackert said the claim that some nurses were denied severance packages does not apply to St. Cloud Hospital.

"All the CRNAs certified registered nurse anesthetists who were employed at the time of the layoffs received severance packages," Mackert said. They were consistent with the standard hospital severance package and included severance pay, continuation of benefits, career counseling and clerical services to assist in job searches, she said.

A spokeswoman from Allina Health System Corp., owner of Mercy in Coon Rapids and Unity in Fridley, declined to comment Wednesday because Allina had not yet been served with the suit. A call Thursday to Allina was not immediately returned.

William S. Rosen, attorney for the nurses, declined to estimate how much money might be involved.

Nurse anesthetists are paid about $75,000 a year, according to the complaint. Anesthesiologists who contract with hospitals can earn as much as $400,000 a year, according to the complaint.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

UNITED STATES OF AMERICA, *ex rel* MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS,

Plaintiffs,

v.

ALLINA HEALTH SYSTEM CORP., UNITY HOSPITAL, MERCY HOSPITAL, MARK SPERRY, M.D., GARY BATGENSTOSS [sic], M.D., JOHN MURPHY, JAMES CUMMING, M.D., JOHN RYDBERG, M.D., MIDWEST ANESTHESIOLOGISTS, P.A., METROPOLITAN ANESTHESIA NETWORK, HEALTH BILLING SYSTEMS, INC., ALLEN TANK, THELMA M. ALBAY, M.D., MINDA CASTILLEJOS, M.D., TERI HEIL, M.D., SANG HONG, M.D., TED JANOSSY, M.D., RAYMOND KLOEPPER II, M.D., JOHN MAGDSICK, M.D., THOMAS MAGGS, M.D., THOMAS POLTA, M.D., JOHN ROSEBERG, M.D., JAI SUH, M.D., JEFFREY YUE, M.D., CRAIG JOHNSON, M.D., ST.

* Civil Action
* File No. 3-94-146

COMPLAINT FOR DAMAGES AND OTHER RELIEF UNDER THE FALSE CLAIMS ACT & DEMAND FOR JURY TRIAL

FILED IN CAMERA AND UNDER SEAL

CLOUD HOSPITAL, ANESTHESIA ASSOCIATIONS OF ST. CLOUD LTD., GARY A. BOEKE, M.D., PHILIP F. BOYLE, M.D., L. MICHAEL ESPELAND, M.D., ALAN D. ESPELIEN, M.D., PAUL J. HALVERSON, M.D., LANSE C. LANG, M.D., A. WADE McMILLAN, M.D., WILLIAM H. RICE, MD., ALLAN REITZ, M.D., and ANNETTE E. ZWICK, M.D., NORTH MEMORIAL HOSPITAL ANESTHESIA P.A., [other, known defendants], Does I through XX

Defendants.

Plaintiffs as and for their Complaint against defendants say:

JURISDICTION AND VENUE

1. This is an action to recover damages and civil penalties on behalf of the United States of America arising out of false and/or fraudulent claims presented by Defendants under the Federal Medicare Program. This action arises under the provisions of Title 31 U.S.C. Section 3729, *et seq.* popularly known as the False Claims Act which provides that the United States District Courts shall have exclusive jurisdiction of actions brought under that Act.

2. Under Section 3732(A), venue is proper in this District because defendants reside in this District and the

acts complained of herein occurred in the State of Minnesota, within this judicial district.

3. Under the Act, this Complaint has been filed *in camera* and will remain under seal for a period of at least sixty (60) days and shall not be served on the Defendant until the Court so orders. The Government may elect to intervene and proceed with the action in sixty (60) days after it receives both the Complaint and the material evidence and information.

PARTIES TO THE ACTION

4. *Qui tam* Plaintiff Minnesota Association of Nurse Anesthetists ("MANA") is an association formed for the purpose of preserving and advancing the profession of Certified Registered Nurse Anesthetists ("CRNAs") in Minnesota and, among other things, to engage in activities to promote and protect the legal rights of its members through, among other things, lobbying efforts, legal action and public relations activities. MANA has standing to bring this complaint for itself and on behalf of the United States Government pursuant to 31 U.S.C. § 3730. Various of MANA's members were employed by defendant hospitals at times relevant to this complaint. Hereafter, MANA will be referred to as "Relator."

5. As required under the False Claims Act, 31 U.S.C. Section 3730(a)(2), Relator has provided to the Attorney General of the United States and to the United States Attorney for the District of Minnesota, simultaneous with the filing of this Complaint, a statement of material evidence and information in Relator's possession related to the Complaint as well as a copy of this Complaint. The disclosure statement supports the existence of overcharges

and false claims by the defendants. MANA is the original source of this information under the Act.

6. Defendant Allina Health System Corp. ("Allina") is a non-profit corporation and integrated health care system.

7. Defendant Unity Hospital ("Unity") is a hospital operating at 550 Osborne Road in Fridley, Minnesota.

8. Defendant Mercy Hospital ("Mercy") is a hospital operating at 4050 Coon Rapids Boulevard in Coon Rapids, Minnesota.

9. Defendant Midwest Anesthesiologists, P.A. ("MAPA") is a Minnesota professional association which engages in, among other things, the provision of anesthesia services to the defendants Unity and Mercy Hospitals.

10. Defendant Metropolitan Anesthesia Network ("MAN") is a professional corporation which owns and controls MAPA, as well as other professional associations with anesthesiologists with privileges at Fairview Southdale Hospital, Fairview Ridges Hospital and several children's hospitals.

11. Defendant Allen Tank ("Tank") at all times pertinent hereto was an employee of either HBS, MAN or MAPA and performed business management function for these groups.

12. Health Billing Systems, Inc. ("HBS") is a Minnesota corporation which is owned and controlled by MAN and is responsible for providing billing services to MAN and MANA employees.

13. Defendants Thelma M. Albay, M.D. ("Albay"), Gary Baggenstoss, M.D. ("Baggenstoss"), Minda Castillejos, M.D. ("Castillejos"), David Cumming, M.D. ("Cumming"), Teri Heil, M.D. ("Heil"), Sang Hong, M.D. ("Hong"), Ted Janossy, M.D. ("Janossy"), Raymond Kloepper, II, M.D. ("Kloepper"), John Magdsick, M.D. ("Magdsick"), Thomas Maggs, M.D. ("Maggs"), Thomas Polta, M.D. ("Polta"), John Roseberg, M.D. ("Roseberg"), Jai Suh, M.D. ("Suh"), Jeffrey Yue, M.D. (Yue"), Mark Sperry, M.D. ("Sperry") and John Rydberg, M.D. ("Rydberg") are medical doctors specializing in anesthesia ("MDAs") who maintained privileges at Unity and/or Mercy Hospitals at all times relevant to this Complaint and are members of MAPA (hereinafter collectively the "Unity/Mercy MDAs").

14. The defendants named in paragraphs 1 through 13 shall be collectively referred to as the "Unity/Mercy defendants".

15. Defendant St. Cloud Hospital ("St. Cloud") is a hospital operating at 1406 6th Avenue N., St. Cloud, Minnesota 56303.

16. Defendant Anesthesia Associates of St. Cloud LTD ("AASC") is a professional partnership located at 816 West St. Germain St. Suite 403, St. Cloud, Minnesota 56301, whose anesthesiologist members maintain privileges at St. Cloud Hospital.

17. Defendants Gary A. Boeke, M.D. ("Boeke"), Philip F. Boyle, M.D. ("Boyle"), L. Michael Espeland, M.D. ("Espeland"), Alan D. Espelien, M.D. ("Espelien"), Paul J. Halverson, M.D. ("Halverson"), Lanse C. Lang, M.D. ("Lang") and A. Wade McMillan, M.D. ("McMillan"), William H. Rice, M.D. ("Rice"), Allan Reitz, M.D. ("Reitz")

and Annette E. Zwick, M.D. ("Zwick") are medical doctors specializing in anesthesia ("MDAs") who maintained privileges at St. Cloud Hospital at all times relevant to this Complaint and are members and/or employees of AASC.

18. Defendants in paragraphs 15 through 17 will hereinafter collectively be referred to as the "St. Cloud defendants."

19. Plaintiffs sue fictitious defendants Does I through XX, inclusive, because their names and/or capacities and/or facts showing them liable are not presently known.

THE ROLES OF ANESTHESIOLOGISTS AND OF CRNAs IN THE PROVISION OF ANESTHESIA

20. Anesthesia is a medical specialty which deals with the management of procedures for rendering a patient insensible to pain during surgical, obstetrical and certain other medical procedures; the support of life functions under the stress of anesthetic and surgical manipulation; the clinical management of the patient unconscious for whatever cause; the management of problems in cardiac and respiratory resuscitation; the application of specific methods of inhalation therapy; and the clinical management of various fluid electrolyte and metabolic disturbances.

21. Certified registered nurse anesthetists are a group of health providers who are virtually unknown to the public at large, yet they administer more that 65% of the 26 million anesthetics given to patients each year in the United States. In 85% of rural hospitals, CRNAs are

the *sole* anesthesia providers providing all aspects of anesthesia, including obstetrical, surgical and trauma stabilization services. While anesthesiologists, who are physicians, are often involved in the delivery of anesthesia services as part of an anesthesia care team, they are frequently absent from the operating room during the administration of anesthesia and for long periods of time during the surgery. It is the CRNA who, in most cases, performs the majority of the anesthesia services and who stays in the operating room with the patient and the surgeon throughout the operation.

22. The principal activity of most anesthesia providers who are in the clinical practice of medicine is in connection with the performance of surgery in a hospital. Ordinarily the patient about to undergo surgery does not choose his anesthesiologist provider. That decision is usually made by the surgeon or assigned to the patient's case by the operating room supervisor or head of the anesthesiology department. It is not uncommon for a patient to have his first contact with the anesthesia provider just prior to being brought into the operating room for surgery.

23. Historically, since World War II, while anesthesia services have been provided in a variety of settings, including CRNAs only, anesthesiologists only, and CRNAs under the direction of physicians or anesthesiologists, the majority of anesthesia care in the United States has been provided by way of anesthesia care teams. The anesthesia care teams are made up of a number of CRNAs who provide the majority of the anesthesia and related services under the direction of and/or supervision of an anesthesiologist. Such teams are the most cost effective method of providing anesthesia care since they utilize lower cost

providers, CRNAs, and they minimize the involvement of substantially higher cost providers, anesthesiologist MDAs.

MEDICARE REGULATIONS RELEVANT TO DEFENDANTS' FALSE CLAIMS

24. Since, on average, hospitals in the Twin Cities area, including defendant hospitals, that provide general surgical services provide approximately 30% of those services to Medicare related patients, Medicare strongly affects the way those hospitals operate.

25. Reimbursement for the provision of anesthesia services has been treated uniquely by Medicare.

26. Prior to 1982, anesthesiologists bills under Part B of Medicare as independent health care practitioners, whereas CRNAs' costs were billed by the hospital under Part A as part of the general costs of providing Medicare services.

27. Under pre-1982 Medicare regulations, anesthesiologists were permitted to supervise as many CRNAs as they wished and to bill for as many cases simultaneously as they wished. There was no limit on the number of concurrent cases for which an anesthesiologist could receive reimbursement for medically directing CRNAs, even though the direct participation of the MDA may have been minimal.

28. In 1982, in part as a result of what was believed to be wide-spread fraudulent billing practices by MDAs, the Tax Equity And Fiscal Responsibility Act of 1982

("TEFRA") was enacted, establishing conditions for anesthesiologists to fulfill in order to be paid for medically directing CRNAs. Those conditions were:

(a) Performs a pre-anesthesia examination and evaluation;

(b) Prescribes the anesthesia plan;

(c) Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence;

(d) Ensures that any procedure in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;

(e) Monitors the course of anesthesia administration at intervals;

(f) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provides indicated post anesthesia care.

29. Subsequently congress passed the Omnibus Budget Reconciliation Act of 1986 ("OBRA '86"), which established the ability for CRNAs to bill directly under Medicare Part B effective January 1, 1989. In practice, since most CRNAs were employed by hospitals, they assigned their independent billing rights to the hospitals, which billed Medicare for the CRNAs' services.

30. Another crucial change which was introduced in OBRA '86 was a change in the methodology for payment of anesthesiologists and nurse anesthetists. 42 C.F.R. 414.450 provided that, in most cases where an anesthesiologist was engaged in a single procedure and was not

involved in any other concurrent cases, the anesthesiologist would be paid 100% of the cost of the procedure regardless of whether any nurse anesthetist was involved. Thus, in such cases, often referred to as "one-on-ones," the anesthesiologists may be paid for 100% of the work even if the CRNA performs the work. In contrast, if an anesthesiologist is involved in two or more concurrent cases, he will receive only a portion of the allocated cost of the procedure and the other portion will be paid to the CRNA. This change was crucial because it permitted an MDA, by fraudulently billing concurrent cases as "one-on-ones," to increase the amount he was paid by Medicare substantially beyond that which he should have been paid.

DEFENDANTS' FALSE CLAIMS

31. This *Qui Tam* complaint is based upon the fact that for years the defendant anesthesiologists, with the knowledge and assistance of the defendant hospitals, have been billing Medicare for services which they either did not perform or which did not qualify for reimbursement under the applicable Medicare laws and regulations. In particular, while the Medicare regulations pertaining to reimbursement for anesthesia services have been amended from time to time, since 1988 an anesthesiologist was only entitled to be personally reimbursed for services provided by him in three specific situations, two of which are relevant here: (1) where he personally performs the anesthesia procedure; and (2) where he medically directs another qualified anesthesia provider (such as a CRNA) in connection with more than one procedure.

32. In order to be reimbursed for personally performing the anesthesia procedure, the anesthesiologist was

required to either (i) "personally perform the entire anesthesia procedure (Section 414.46(2)(i); or (ii) be "continuously involved in a single case involving a certified registered nurse anesthetist, an anesthetist assistant or a student nurse anesthetist" (Section 4.4.46(2)(ii)).

33. The United States Government and its Medicare intermediaries have repeatedly clarified that in order to be reimbursed for personally performing an anesthesia procedure, the anesthesiologist, at a minimum, *must be in the operating suite for the entire time that the procedure is being performed. Medicare News No. 123,* September 1993 ("for the anesthesiologist to bill using the AA modifier (a code for personally performed anesthesia procedure), he must be physically present in the operating suite while the CRNA is attending to the case. If the anesthesiologist is not continuously involved with the case, then it is considered neither personally performed nor medically directed"); *Letter Interpretation dated January 7, 1994 from the Division of Medical Services Payment Bureau of Policy Development to the American Society of anesthesiologists;* CCH *Medicare and Medicaid Guide* ¶ 3455, *Medicaid Carriers Manual* § 15018. Accordingly, if the anesthesiologist is not, at a minimum, continuously present at and involved in an anesthesia procedure, he is not entitled to reimbursement from Medicare for personally performing that procedure.

34. Relator's members have personal knowledge, however, that defendant anesthesiologists have routinely billed Medicare for personal performance of anesthesia procedures in which they were *not* continuously involved or present, as required by Medicare. Those bills were for services for which the defendant anesthesiologists knew they were not entitled to reimbursement from Medicare,

and were false or fraudulent claims within the meaning of 31 U.S.C. 3729.

35. The second basis for Medicare reimbursement of a physician anesthesiologist is for medically directing a CRNA or other anesthesia provider in two or more concurrent anesthesia procedures. In order to be entitled to such reimbursement, the anesthesiologist need not be present in the operating room at all times. As previously noted, however, he must comply with the following conditions:

(1) For each patient, the physician must –

(i) Perform a pre-anesthetic examination and evaluation;

(ii) Prescribe the anesthesia plan;

(iii) Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergency;

(iv) Ensure that any procedures in the anesthesia plan that he or she doe snot perform are performed by a qualified individual as defined in program operating instructions;

(v) Monitor the course of anesthesia administration at frequent intervals;

(vi) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provide indicated post-anesthesia care.

42 C.F.R. 405.552.

36. Relator's members have personal knowledge that during the past six (6) years defendant anesthesiologists

have billed for medically directed services without complying with the conditions set forth in 42 C.F.R. § 405.552. Those bills were for services for which the anesthesiologists knew they were not entitled to reimbursement from Medicare and were false or fraudulent claims under Section 3729.

37. For example, defendant anesthesiologists contravened the requirements of §405.552 by billing Medicare for medical direction as to procedures during which:

(a) They were not in the operating room during induction;

(b) They were not in the operating room during emergence;

(c) They were not in the hospital during a portion of the anesthesia procedure;

(d) They were not in the operating suite during a portion of the procedure;

(e) They were involved in personally performing procedures in another operating room or suite and, therefore, not available to participate in "the most demanding procedures in the anesthesia plan" or to "remain physically present and available for immediately diagnosis and treatment for emergencies"; and/or

(f) They were impermissibly supervising more than four concurrent procedures.

38. Defendant anesthesiologists also contravened the requirements of §405.552 as follows. Medicare does not provide reimbursement to anesthesiologists in a group practice for medical supervision of a procedure where one

member of the group substitutes for another during the course of the procedure, except as follows:

> If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who rendered them.

CCH Medicare and Medicaid Guide, ¶3455.40, *Medicaid Carriers Manual*, §15018(C). Relator's members have personal knowledge that defendant anesthesiologists in group practices billed Medicare for medical direction of procedures during the course of which one group member had taken over the procedure from another under circumstances which precluded reimbursement from Medicare. Those bills were for services as to which the defendant anesthesiologists knew they were not entitled to reimbursement from Medicare, and were false or fraudulent claims within the meaning of 31 U.S.C.§3729. The defendant anesthesiologists have knowingly concealed such false claims by failing to sign in and out of the operating room during such procedures, thereby depriving Medicare of a standard medical record which, if fully and accurately prepared, would reveal defendants' fraud.

39. As CRNA's who daily worked alongside the defendant anesthesiologists at the defendant hospitals, Relator members have personal knowledge of defendants'

false claims by virtue of communications with defendants themselves, participation in the anesthesia procedures which were later fraudulently billed by the defendant anesthesiologists, and familiarity with hospital records disclosing defendants' fraud.

40. While defendant anesthesiologists have attempted to conceal their fraudulent billing, Relator's members learned of defendants' fraud when Medicare and others began rejecting true and accurate bills from the Defendant hospitals for anesthesia procedures performed by Relator's members on the ground that defendant anesthesiologists had already billed for personal performance of those procedures and been reimbursed.

41. At all times, defendant hospitals have been or should have been aware that defendant anesthesiologists were presenting false claims to Medicare. Rather than taking steps to prevent the fraud, however, Defendant hospitals have knowingly facilitated it.

42. Among other things, Defendant hospitals have knowingly (1) permitted defendant anesthesiologists to bill in a manner which impedes discovery of their false claims; (2) refused to require defendant anesthesiologists to sign in and out of operating rooms; (3) ignored complaints by Relator's members concerning the anesthesiologists' false and fraudulent billing practices; and (4) retaliated against Relator's members for reporting such fraud.

43. Most notably, after CRNAs (members of Relator) at defendants Unity and Mercy Hospitals reported to those hospitals and produced to them records documenting instances of fraudulent billing by anesthesiologist defendants, those hospitals, in concert with the anesthesiologists, fired the CRNAs and pressured them to become

employed by the anesthesiologists. Essentially the same scenario unfolded at defendant St. Cloud Hospital. These defendants were motivated by (1) the desire of the anesthesiologists to continue their fraudulent billing practices; and (2) the desire of the hospitals to avoid confrontation with the anesthesiologists over – but simultaneously to distance themselves from – the anesthesiologists' fraud. The firing by the hospitals and rehiring by the anesthesiologists of the CRNAs was calculated to accomplish these purposes by giving the anesthesiologists sole control over billing for all anesthesiological services – whether performed by the MDAs themselves, by CRNAs themselves, or by a combination of the two – thereby eliminating the risk that CRNAs would continue to expose the anesthesiologists' fraud by submitting to Medicare and others separate bills belying the fraudulent bills submitted by the anesthesiologists.

44. It is estimated that between 1988 and 1994 defendant anesthesiologists submitted in excess of 40,000 individual claims for reimbursement to Medicare for services performed at defendant hospitals. Relator is informed and believes that approximately 70% of these claims were false or fraudulent claims under Section 3729.

45. Accordingly, Relator estimates that approximately Twenty-Eight Thousand (28,000) false and/or fraudulent Medicare Part B claims were presented by defendants to the United States Government, its officers and/or employees. Relators estimate that the dollar amount defendants thereby fraudulently obtained exceeds Two Million Dollars ($2,000,000).

46. Defendants are liable under 31 U.S.C. §§ 3729 and 3730 for (a) penalties in the maximum amount of Ten

Thousand Dollars ($10,000.00) for each of these approximately 28,000 claims, plus (b) three times the amount of damages which the Government has sustained as a result of defendants' false claims.

COUNT ONE

47. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 46 as if the same were set forth herein.

48. Defendants have knowingly presented, or caused to be presented, to officers or employees of the United States Government, false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1).

COUNT TWO

49. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 48 if same were set forth herein.

50. Defendants have knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by the Government in violation of 31 U.S.C. § 3729(a)(2).

COUNT THREE

51. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 50 as if same were set forth herein.

52. Defendants have conspired to defraud the Government by getting false or fraudulent claims allowed or paid in violation of 31 U.S.C. § 3729(a)(3).

COUNT FOUR

53. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 52 as if same were set forth herein.

54. Defendants have knowingly made, used, or caused to be made or used, false records or statements to conceal, avoid, or decrease obligations to pay or transmit money or property to the Government in violation of 31 U.S.C. § 3729(a)(7).

COUNT FIVE

55. In addition to the misconduct described in the foregoing Counts, defendant hospitals have violated their obligations under their provider agreements with Medicare and have further conspired with defendant anesthesiologists to submit false and/or fraudulent claims to the United States Government.

WHEREFORE, plaintiffs demand judgment against defendants, and each of them, as follows:

a. That by reason of the violations of the False Claims Act as set out in the First through Fourth Causes of Action, this Court enter judgment against Defendants in an amount up to Three (3) times the amount of damages the United States Government has sustained because of Defendants' actions, plus a civil penalty of not less than Five Thousand Dollars ($5,000.00) and not more than Ten Thousand Dollars ($10,000.00) for each violation of 31 U.S.C. §3729;

b. That Relator as *Qui Tam* Plaintiff be awarded the maximum amount allowed pursuant to Section 3730(d)

of the False Claims Act and/or any other applicable provision of law;

c. That Relator be awarded all costs of this action, including attorneys' fees and court costs;

d. That Relator be awarded its expenses in connection with this action pursuant to 31 U.S.C. Section 3729.

e. That appropriate injunctive relief pursuant to 31 U.S.C. §3730(h) be awarded to Relator's members and others who have or may take lawful action in furtherance of this Complaint; and

f. That Plaintiff and the Relator receive such other and further relief as the Court may deem to be just and proper.

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BY: /s/ Herbert J. Stern
Herbert J. Stern (3169)
Attorneys for Plaintiffs

Dated: December 28, 1994

TRIAL BY JURY

Plaintiffs hereby demand a trial by jury as to all issues.

WILLIAM S. ROSEN, ESQ.
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BY: /s/ Herbert J. Stern
Herbert J. Stern (3169)
Attorneys for Plaintiffs

Dated: December 28, 1994

Supreme Court, U.S.
FILED

No. 02- 27 JUN 27 2002

OFFICE OF THE CLERK

In The
Supreme Court of the United States

ALLINA HEALTH SYSTEM CORP., ET AL.,

Petitioners,

v.

UNITED STATES OF AMERICA, EX REL.
MINNESOTA ASSOCIATION OF
NURSE ANESTHETISTS,

Respondent.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Eighth Circuit**

**APPENDIX
VOLUME II, PAGES 226 to 474**

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

UNITED STATES OF AMERICA, ex rel MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS,	*	Civil Action File No. 4-96-734
v.	*	
ALLINA HEALTH SYSTEM CORP., UNITY HOSPITAL, MERCY HOSPITAL, JOHN MURPHY, MIDWEST ANESTHESIOLOGISTS, P.A., METROPOLITAN ANESTHESIA NETWORK, ALLEN TANK, HEALTH BILLING SYSTEMS, INC., THELMA M. ALBAY, M.D., GARY BAGGENSTOSS, M.D., MINDA CASTILLEJOS, M.D., DAVID CUMMING, M.D., TERI HEIL, M.D., SANG HONG, M.D., TED JANOSSY, M.D., RAYMOND KLOEPPER, II, M.D., JOHN MAGDSICK, M.D., THOMAS MAGGS, M.D., THOMAS POLTA, M.D., JOHN ROSEBERG, M.D., JAI SUH, M.D., MARK SPERRY, M.D., JEFFREY YUE, M.D., and JOHN RYDBERG, M.D., ST. CLOUD HOSPITAL, ANESTHESIA ASSOCIATES OF ST. CLOUD LTD., GARY A. BOEKE, M.D., PHILIP F. BOYLE, M.D., L. MICHAEL ESPELAND, M.D., ALAN D. ESPELIEN, M.D., PAUL J. HALVERSON, M.D., CRAIG JOHNSON, M.D., LANSE C. LANG, M.D., A. WADE McMILLAN, M.D., WILLIAM H. RICE, M.D., ALLAN REITZ, M.D., ANNETTE E.	*	THIRD AMENDED COMPLAINT

ZWICK, M.D., ANESTHESIOLOGY, P.A., ABBOTT NORTHWESTERN HOSPITAL, NORTHWEST ANESTHESIA, P.A., BRYCE BEVERLIN, M.D., RICHARD BLOMBERG, M.D., JEAN BOENING, M.D., MITCHELL BURKE, M.D., RAJARAO DWARAKANATH, M.D., RICHARD ENGWALL, M.D., JAMES GAYES, M.D., LUIS GIRON, M.D., NANCY GROVES, M.D., JONATHAN GUDMAN, M.D., RICHARD JOHNSON, M.D., JOHN LILLEHEI, M.D., ROBERT McKLVEEN, M.D., JUDITH MEISNER, M.D., MICHAEL MENZEL, M.D., JAMES MUSICH, M.D., MARK NISSEN, M.D., XAVIER PEREIRA, M.D., DAVID PLUT, M.D., JEFFREY SHAW, M.D., RICHARD SKOOG, M.D., WILLIAM STAUFFER, M.D., OFELIO TIU, M.D., ROBERT TRONNIER, M.D., JOHN WINTERMUTE, M.D., and [other unknown defendants], Does I through XX

Defendants.

****

Plaintiffs as and for their Third Amended complaint against defendants say:

JURISDICTION AND VENUE

1. This is an action to recover damages and civil penalties on behalf of the United States of America arising out of false and/or fraudulent claims presented by Defendants under the Federal Medicare Program. This action

arises under the provisions of Title 31 U.S.C. Section 3729, *et seq.* popularly known as the False Claims Act which provides that the United States District Courts shall have exclusive jurisdiction of actions brought under that Act.

2. Under Section 3732(A), venue is proper in this District because defendants reside in this District and the acts complained of herein occurred in the State of Minnesota, within this judicial district.

PARTIES TO THE ACTION

3. *Qui tam* Plaintiff Minnesota Association of Nurse Anesthetists ("MANA") is an association formed for the purpose of preserving and advancing the profession of Certified Registered Nurse Anesthetists ("CRNAs") in Minnesota and to engage in activities to promote and protect the legal rights of its members through, among other things, lobbying efforts, legal action and public relations activities. MANA has standing to bring this complaint for itself and on behalf of the United States Government pursuant to 31 U.S.C. § 3730. Various of MANA's members were employed by defendant hospitals at times relevant to this complaint. Hereafter, MANA will alternatively be referred to as "Relator."

4. Under the Act, the Complaint must be filed *in camera* and remain under seal for a period of at least sixty (60) days and shall not be served on the Defendant until the Court so orders. The Government may elect to intervene and proceed with the action in sixty (60) days after it receives both the Complaint and the material evidence and information or to authorize the Relator to prosecute the action on the Government's behalf. Plaintiffs have complied with these provisions.

5. On May 17, 1995, the Government requested the Court to unseal this action and authorized MANA to pursue the action in the name of the United States. The Court unsealed the action by Order dated May 23, 1995. Since that time the Government has monitored the action and reviewed copies of discover, motions and pleadings in the case.

6. As required under the False Claims Act, 31 U.S.C. § 3730 (a) (2), Relator has provided to the Attorney General of the United States and to the United States Attorney for the District of Minnesota, simultaneous with the filing of the Complaint, a statement of material evidence and information in Relator's possession related to the Complaint as well as a copy of this Complaint. The disclosure statement supports the existence of overcharges and false claims by the defendants. MANA is the original source of this information under the Act.

7. Defendant Allina Health System Corp. ("Allina") is a nonprofit corporation and integrated health care system.

8. Defendant Unity Hospital ("Unity") is a hospital operating at 550 Osborne Road in Fridley, Minnesota.

9. Defendant Mercy Hospital ("Mercy") is a hospital operation at 4050 Coon Rapids Boulevard in Coon Rapids, Minnesota.

10. Defendant John Murphy currently and was at all times pertinent hereto Vice President of Unity and Mercy Hospitals. He was personally advised by CRNA members of MANA of the fraud alleged herein in 1992.

11. Defendant Midwest Anesthesiologists, P.A. ("MAPA") is a Minnesota professional association which

engages in, among other things, the provision of anesthesia services to the defendants Unity and Mercy Hospitals.

12. Defendant Metropolitan Anesthesia Network ("MAN") is a professional corporation which owns and controls MAPA, as well as other professional associations with anesthesiologists with privileges at Unity and several other Minnesota Hospitals.

13. Health Billing Systems, Inc. ("HBS") is a Minnesota corporation which is owned and controlled by MAN and is responsible for providing billing services to MAN and MAPA employees. On information and belief, Allen Tank is a principal of HBS.

14. Defendant Allen Tank ("Tank") at all times pertinent hereto was an employee of either HBS, MAN or MAPA and performed business management functions for these groups, including billings for anesthesia which it is alleged were deceptive and fraudulent.

15. Defendants Thelma M. Albay, M.D. ("Albay"), Gary Baggenstoss, M.D. ("Baggenstoss"), Minda Castillejos, M.D. ("Castillejos"), David Cumming, M.D. ("Cumming"), Teri Heil, M.D. ("Heil"), Sang Hong, M.D. ("Hong"), Ted Janossy, M.D. ("Janossy"), Raymond Kloepper, II, M.D. ("Kloepper"), John Magdisick, M.D. ("Magdsick"), Thomas Maggs, M.D. ("Maggs"), Thomas Polta, M.D. ("Polta"), John Roseberg, M.D. ("Roseberg"), Jai Suh, M.D. ("Suh"), Mark Sperry, M.D. ("Sperry"), Jeffrey Yue, M.D. (Yue") and John Rydberg, M.D. ("Rydberg") are medical doctors specializing in anesthesia ("MDAs") who maintained privileges at Unity and/or Mercy Hospitals at all times relevant to this Complaint and are members of MAPA (hereinafter collectively the "Unity/Mercy MDAs").

16. The defendants named in paragraphs 7 through 15 shall be collectively referred to as the "Unity/Mercy defendants".

17. Defendant St. Cloud Hospital ("St. Cloud") is a hospital operating at 1406 6th Avenue N., St. Cloud, Minnesota 56303.

18. Defendant Anesthesia Associates of St. Cloud Ltd. ("AASC") is a professional partnership located at 816 West St. Germain St. Suite 403, St. Cloud, Minnesota 56301, whose anesthesiologists members maintain privileges at St. Cloud Hospital.

19. Defendants Gary A. Boeke, M.D. ("Boeke"), Philip F. Boyle, M.D. ("Boyle"), L. Michael Espeland, M.D. ("Espeland"), Alan D. Espelien, M.D. ("Espelien"), Paul J. Halverson, M.D. ("Halverson"), Craig Johnson, M.D. ("Johnson"), Lanse C. Lang, M.D. ("Lang") and A. Wade McMillan, M.D. ("McMillan"), William H. Rice, M.D. ("Rice"), Allan Reitz, M.D. ("Reitz") and Annette E. Zwick, M.D. ("Zwick") are medical doctors specializing in anesthesia ("MDAs") who maintained privileges at St. Cloud Hospital at all times relevant to this Complaint and are members and/or employees of AASC.

20. Defendants in paragraphs 17 through 19 will hereinafter collectively be referred to as the "St. Cloud defendants."

21. Defendant Anesthesiology, P.A. ("APA") is a professional association which, among other things, provides anesthesia services to North Memorial Hospital.

22. Defendant Abbott Northwestern Hospital is a hospital operating at East 28th Street, Minneapolis,

Minnesota. Abbott Northwestern is owned by defendant Allina.

23. Defendant Northwest Anesthesia, P.A. ("NWA") is a Minnesota professional corporation which, among other things, provides anesthesia services to Abbott Northwestern.

24. Defendants Bryce Beverlin, M.D. ("Beverlin"), Richard Blomberg, M.D. ("Blomberg"), Jean Boening, M.D. ("Boening"), Mitchell Burke, M.D. ("Burke"), Rajarao Dwarakanath, M.D. ("Dwarakanath"), Richard Engwall, M.D. ("Engwall"), James Gayes, M.D. ("Gayes"), Luis Giron, M.D. ("Giron"), Nancy Groves, M.D. ("Groves"), Jonathan Gudman, M.D. ("Gudman"), Richard Johnson, M.D. ("Johnson"), John Lillehei, M.D. ("Lillehei"), Robert McKlveen, M.D. ("McKlveen"), Judith Meisner, M.D. ("Meisner"), Michael Menzel, M.D. ("Menzel"), James Musich, M.D. ("Musich"), Mark Nissen, M.D. ("Nissen"), Xavier Pereira, M.D. ("Pereira"), David Plut, M.D. ("Plut"), Jeffrey Shaw, M.D. ("Shaw"), Richard Skoog, M.D. ("Skoog"), William Stauffer, M.D. ("Stauffer"), Ofelio Tiu, M.D. ("Tiu"), Robert Tronnier, M.D. ("Tronnier") and John Wintermute, M.D. ("Wintermute") are medical doctors specializing in anesthesia ("MDAs") who maintained privileges at Abbott Northwestern Hospital at all times relevant to this Complaint and are members and/or employees of NWA (hereinafter collectively the "Abbott Northwestern MDAs").

25. Defendants in paragraphs 22 through 24 will hereinafter collectively be referred to as the "Abbott Northwestern" defendants.

26. Plaintiffs sue fictitious defendants Does I through XX, inclusive, because their names and/or capacities and/or facts showing them liable are not presently known.

27. All of the Hospital defendants named above shall hereinafter alternatively be referred to as "the defendant hospitals."

28. All of the anesthesiologist defendants and their professional associations named above shall hereinafter be collectively alternatively referred to as "the defendant anesthesiologists."

THE ROLES OF ANESTHESIOLOGISTS AND OF CRNAs IN THE PROVISION OF ANESTHESIA

29. Anesthesia is a medical specialty which deals with the management of procedures for rendering a patient insensible to pain during surgical, obstetrical and certain other medical procedures; the support of life functions under the stress of anesthetic and surgical manipulation; the clinical management of the patient unconscious for whatever cause; the management of problems in cardiac and respiratory resuscitation; the application of specific methods of inhalation therapy; and the clinical management of various fluid electrolyte and metabolic disturbances.

30. Certified registered nurse anesthetists are a group of health providers who are virtually unknown to the public at large, yet they administer more the 65% of the 26 million anesthetics given to patients each year in the United States. In 85% of rural hospitals, CRNAs are the *sole* anesthesia providers providing all aspects of

anesthesia, including obstetrical, surgical and trauma stabilization services. While anesthesiologists, who are physicians, are often involved in the delivery of anesthesia services as part of an anesthesia care team, they are frequently absent from the operating room during the administration of anesthesia and for long periods of time during the surgery. It is the CRNA who, in most cases, performs the majority of the anesthesia services and who stays in the operating room with the patient and the surgeon throughout the operation.

31. The principal activity of most anesthesia providers who are in the clinical practice of medicine is in connection with the performance of surgery in a hospital. Ordinarily the patient about to undergo surgery does not choose his anesthesia provider. That decision is usually made by the surgeon or assigned to the patient's case by the operating room supervisor or head of the anesthesia department. It is not uncommon for a patient to have his first contact with the anesthesia provider just prior to being brought into the operating room for surgery.

32. Historically, since World War II, while anesthesia services have been provided in a variety of settings, including CRNAs only, anesthesiologists only, and CRNAs under the direction of physicians or anesthesiologists, the majority of anesthesia care in the United States has been provided by way of anesthesia care teams. The anesthesia care teams are made up of a number of CRNAs who provide the majority of the anesthesia and related services under the direction of and/or supervision of an anesthesiologist. Such teams are the most cost effective method of providing anesthesia care since they utilize lower cost providers, CRNAs, and they minimize the involvement of

substantially higher cost providers, anesthesiologist MDAs.

MEDICARE REGULATIONS RELEVANT TO DEFENDANTS' FALSE CLAIMS

33. Since, on average, hospitals in the Twin Cities area, including defendant hospitals, that provide general surgical services provide approximately 30% of those services to Medicare related patients, Medicare strongly affects the way those hospitals operate. In addition, many private insurers look to Medicare regulations to guide their insurance reimbursement policies.

34. Reimbursement for the provision of anesthesia services has been treated uniquely by Medicare.

35. Prior to 1982, anesthesiologists billed under Part B of Medicare as independent health care practitioners, whereas CRNAs' costs were billed by the hospital under Part A as part of the general costs of providing Medicare services.

36. Under pre-1982 Medicare regulations, anesthesiologists were permitted to supervise as many CRNAs as they wished and to bill for as many cases simultaneously as they wished. There was no limit of the number of concurrent cases for which an anesthesiologists could receive reimbursement for medically directing CRNAs, even though the direct participation of the MDA may have been minimal.

37. In 1982, in part as a result of what was believed to be widespread fraudulent billing practices by MDAs, the Tax Equity and Fiscal Responsibility Act of 1982

("TEFRA") was enacted, establishing conditions for anesthesiologists to fulfill in order to be paid for medically directing CRNAs. Those conditions were:

(a) Performs a pre-anesthesia examination and evaluation;

(b) Prescribes the anesthesia plan;

(c) Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence;

(d) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;

(e) Monitors the course of anesthesia administration at frequent intervals;

(f) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provides indicated post anesthesia care.

38. Subsequently Congress passed the Omnibus Budget Reconciliation Act of 1986 ("OBRA '86"), which established the ability for CRNAs to bill directly under Medicare Part B effective January 1, 1989. In practice, since most CRNAs were employed by hospitals, they assigned their independent billing rights to the hospitals, which billed Medicare for the CRNAs' services.

39. Another crucial change which was introduced in OBRA '86 was a change in the methodology for payment of anesthesiologists and nurse anesthetists. 42 C.F.R. 414.450 provided that, in most cases where an anesthesiologists was engaged in a single procedure and was not

involved in any other concurrent cases, the anesthesiologists would be paid 100% of the cost of the procedure regardless of whether any nurse anesthetists was involved. Thus, in such cases, often referred to as "one-on-ones," the anesthesiologists may be paid for 100% of the work even if the CRNA performs the work. In contrast, if an anesthesiologist is involved in two, three or four concurrent cases, he will receive only a portion of the allocated cost of the procedure and the other portion will be paid to the CRNA. This change was crucial because it permitted an MDA, by fraudulently billing concurrent cases as "one-on-ones," to increase the amount he was paid by Medicare substantially beyond that which he should have been paid.

DEFENDANTS' FALSE CLAIMS

40. This *Qui Tam* complaint is based upon the fact that for years the defendant anesthesiologists, with the knowledge and active assistance of the defendant hospitals, have been billing Medicare for services which they either did not perform or which did not qualify for reimbursement under the applicable Medicare laws and regulations. In particular, while the Medicare regulations pertaining to reimbursement for anesthesia services have been amended from time to time, since January 1988 an anesthesiologists was only entitled to be personally reimbursed for services provided by him in three specific situations, two of which are relevant here: (1) where he personally performs the anesthesia procedure; and (2) where he medically directs another qualified anesthesia provider (such as a CRNA) in connection with two, three or four procedures.

41. In order to be reimbursed for personally performing the anesthesia procedure, the anesthesiologist is required to either (1) "personally perform the entire anesthesia procedure (42 C.F.R. 414.46 (2) (i); or (2) be "continuously involved in a single case involving a certified registered nurse anesthetist ("CRNA"), an anesthesiologist assistant ("AA") or a student nurse anesthetist" (42 C.F.R. 414.46 (2) (ii)). Cases where one MDA works with one CRNA are often referred to as "one-on-one" cases.

42. In order to be continuously involved in a single case, the anesthesiologist must be present in the operating room for the entire time. In particular, 42 C.F.R. 4:14.46 provides that billing for anesthesia services is based upon base units which assign a value to each anesthesia procedure and "time units" which "involve the *continuous actual presence* of the physician . . . and starts when he or she begins to prepare the patient for anesthesia . . . and ends when the anesthesiologist . . . *is no longer in personal attendance*." In contrast, where the physician is "medically directing" a CRNA which may only occur in connection with two, three or four concurrent procedures, time units may be billed based on the "presence" of the "medically directed" CRNA. Because the MDA must be present with the CRNA at all times to be reimbursed for personally performing a procedure, Section 4:14.46 also provides that where the anesthesiologist personally performs the procedure, he receives the full fee and no payment will be made to the CRNA unless the CRNA's presence is "medically necessary". See 42 C.F.R. 4:14.46 (c) (3). The requirement that an anesthesiologist must be in the operating room for the entire time if he seeks to be reimbursed for personally performing a procedure and may not be engaged for any amount of time in other activities was confirmed on

numerous occasions in letter interpretations issued by the Department of Health & Human Services. On December 9, 1987 the Director of the Office of Reimbursement Policy, Bureau of Eligibility, Reimbursement Coverage responsible for officially interpreting Medicare regulations regarding reimbursement wrote to St. Cloud defendants' Medicare carrier, Blue Shield and stated the following:

> "It is our opinion that 42 CFR 405.552 (a) (2) refers to two patterns of anesthesia administration payable on a reasonable charge basis. Either the anesthesiologist performs the procedure directly without the assistance of an anesthetist or the anesthesiologist medically directs anesthesia during concurrent procedures. Medical direction would occur in the context of concurrent procedures not a single procedure. In the situation where the anesthesiologist is involved in a single anesthesia procedure involving a CRNA, we would deem the procedure to be performed by the anesthesiologist . . . we would deem an anesthesia procedure as personally performed by an anesthesiologist as long as the anesthesiologist was *continuously present with the CRNA* for those services that the anesthesiologist does not personally perform and the anesthesiologist is not involved in any other anesthesia procedure."

Subsequently in its administrative bulletins issued in March 1988 to defendant anesthesiologists Blue Cross/Blue Shield stated:

> "We deem the anesthesia procedure as personally performed by the anesthesiologist as long as the anesthesiologist was continually present with the

> CRNA for those services that the anesthesiologist does not personally perform and the anesthesiologist is not involved in any other anesthesia procedure."

Again, on August 10, 1990, Blue Cross/Blue Shield issued another bulletin stating in pertinent part

> "Personally furnished anesthesia services are provided personally by the anesthesiologist to an individual patient. You cannot bill for personally furnished anesthesia if you are also simultaneously involved with the delivery of anesthesia services for any other patient."

Furthermore, in a memorandum to defendant, John Murphy, on December 14, 1992, is written:

> In order to qualify to receive reimbursement for personal delivery (1/1) of a service, the anesthesiologist must be *continuously present* with the CRNA (if a CRNA is also involved) for those services, the anesthesiologist does not personally perform, and the anesthesiologist cannot be involved in any other anesthesia procedure." (April 1988 Medicare Bulletin, Administrative Bulletin #177.)

Finally, as recently as January 7, 1994, Bernard Patashnick, Director of the Division of Medical Services Payment Bureau of Policy Development wrote to the American Society of Anesthesiologists stated the following:

> "The anesthesiologist who is billing for personal performance of the case *must personally perform the case*. In theory, there is *no one else to hand the case to*. In the medically directed case we do not require the anesthesiologist to personally perform all anesthesia activities. In fact, many of these activities are performed by the CRNA."

Consequently, an MDA cannot bill one-to-one if the foregoing criteria are not met, even if the MDA participated in some portion of the process. As recently as April 1996, HCFA confirmed in a letter to the private carrier who administers defendant MDAs' claims that HCFA requires the anesthesiologist to remain in the operating room in billing for personally performed cases. In that same letter, HCFA confirmed that medical direction of single procedures does not exist. Defendants have been provided with copies of this letter.

43. The defendant hospitals were on notice as early as December 19, 1987, that the defendant anesthesiologists were billing fraudulently. Moreover, between 1990 and 1992, CRNAs at those hospitals reported the fraud. For example, at Unity Mercy, copies of charts showing that MDAs were fraudulent [sic] billing and were actually in other operating rooms at the time were provided to in-house counsel for Allina and to defendant Murphy, yet the hospital did not report this fraud to any governmental agency. At St. Cloud Hospital, Jerry Boldon, a CRNA, wrote a memo disclosing the fraud to administrators. However, instead of taking steps to stop the MDA's fraud, the hospitals fired Relator's members who had brought the fraud to their attention and knowingly facilitated the continuation of the fraud.

44. Relator's members have personal knowledge that defendant anesthesiologists have routinely billed Medicare for personal performance of anesthesia procedures in which they were *not* continuously involved or present, as required by Medicare. Those bills were for services for which the defendant anesthesiologists knew they were not entitled to reimbursement from Medicare, and were false or fraudulent claims within the meaning of 31 U.S.C.

3729. Defendant MAN used the services of defendants Tank and HBAS who knowingly billed on their behalf for services which they knew or should have known were not performed by them.

45. The second basis for Medicare reimbursement of a physician anesthesiologist is for medically directing a CRNA or other anesthesia provider in two, three or four concurrent anesthesia procedures. In order to be entitled to such reimbursement, the anesthesiologist need not be present in the operating room at all times. As previously noted, however, he must comply with the following conditions:

(1) For each patient, the physician must –

(i) Perform a preanesthetic examination and evaluation;

(ii) Prescribe the anesthesia plan;

(iii) Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence;

(iv) Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions;

(v) Monitor the course of anesthesia administration at frequent intervals;

(vi) Remain physically present and available for immediate diagnosis and treat of emergencies; and

(vii) Provide indicated post-anesthesia care.

42 C.F.R. 405.552.

46. Relator's members have personal knowledge that during the past six (6) years defendant anesthesiologists have billed for medically directed services and personally performed services without complying with the conditions set forth in 42 C.F.R. § 405.552. Those bills were for services for which the defendant anesthesiologists knew they were not entitled to reimbursement from Medicare and were false or fraudulent claims under Section 3729.

47. In particular, defendant Northwest Anesthesia engaged in similar false billing practices and false claims in connection with the provision of anesthesia services at Abbott Northwestern Hospital. For example, anesthesiologists who work for NWA and provide services at Abbott Northwestern have on numerous occasions billed for personally performing operations when they were only present in the operating room for a fraction of the actual anesthesia time. Relator has supplied to the Government affidavits from members of MANA who have been at Abbott Northwestern which state that the anesthesiologists who provided anesthesia services at operations in which those CRNAs were involved were "virtually never present for the entire time." Similar statements confirm that anesthesiologists often left the operating room after starting cases late in the day and never returned. Relator has also obtained and supplied to the Government numerous rejection documents reflecting operations or procedures which were billed by the defendant Abbott Northwestern anesthesiologists as "personally performed" which Relator is informed and believe were false and fraudulent. In order to facilitate this fraud, Allina and Abbott Northwestern have announced plans to terminate all of their CRNA employees. Relator and the Government are informed and believe that this termination was not

because the CRNAs were not economically viable but rather in order to force the CRNAs to be employed by the defendant MDAs and thereby to simultaneously distance the hospital from the defendant anesthesiologists' fraudulent billing practices.

48. Defendant anesthesiologists also contravened the requirements of §405.552 as follows. Medicare does not provide reimbursement to anesthesiologists in a group practice for medical supervision of a procedure where one member of the group substitutes for another during the course of the procedure, except as follows:

> If anesthesiologists are in a group practice, one physician member may provide pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who rendered them.

CCH Medicare and Medicaid Guide, ¶3455.40, *Medicaid Carriers Manual*, §15018 (C). Relator's members have personal knowledge that defendant anesthesiologists in group practices billed Medicare for medical direction of procedures during the course of which one group member had taken over the procedure from another under circumstances which precluded reimbursement from Medicare. Those bills were for services as to which the defendant anesthesiologists knew they were not entitled to reimbursement from Medicare, and were false or fraudulent claims within the meaning of 31 U.S.C. §3729. The defendant

anesthesiologists have knowingly concealed such false claims by failing to sign in and out of the operating room during such procedures, thereby depriving Medicare of a standard medical record which, if fully and accurately prepared, would reveal defendants' fraud. Defendant hospitals have assisted them in this fraud by refusing to require them to sign in and out of the operating room, and in the case of defendants Unity and Mercy, by refusing to require defendant anesthesiologists to carry "pagers" or "beepers."

49. As CRNA's who daily worked alongside the defendant anesthesiologists at the defendant hospitals, Relator members have personal knowledge of defendants' false claims by virtue of communications with defendants themselves, participation in the anesthesia procedures which were later fraudulently billed by the defendant anesthesiologists, and familiarity with hospital records disclosing defendants' fraud.

DEFENDANTS' FRAUDULENT SCHEME

50. As previously alleged, since the 1983 TEFRA regulations went into effect in November 1983, Medicare has only recognized two ways for anesthesiologists to be paid for anesthesia services: (1) personally performing a procedure and (2) medically directing 2, 3, or 4 procedures. HCFA has never recognized medical direction of one procedure. As early as 1987, in a letter to one of the Minnesota carriers to which defendants had access, Charles Booth, Director of Policy and Reimbursement for HCFA, stated in no uncertain terms that there is no such thing as medical direction of a single procedure. Moreover, in order to bill for personal performance of a procedure,

the anesthesiologist must either (1) personally perform every aspect of the anesthesia procedure on the patient and be present for the entire time, or (2) be continuously present with the patient and a CRNA and continuously involved with the case. These requirements make simple common sense since when the anesthesiologist is involved in a procedure with one CRNA, he is paid as if he performed every aspect of the procedure by himself without assistance and in most cases the CRNA receives nothing.

51. The requirement of continuous presence in the operating room has been repeated by HCFA since 1987. It is contained in Bulletins issued by Blue Cross/Blue Shield, the carrier for the St. Cloud defendants; it is contained in letters to the American Society of Anesthesiologists which were republished in Newsletters available to defendants; and it was enforced by government enforcement authorities in Minnesota who investigated another hospital owned by the Allina defendant for similar types of fraud.

52. As for medical direction of two, three and four procedures, the rules are very strict if an anesthesiologist seeks to be reimbursed. Of particular interest in this case, the anesthesiologist must be present in the operating room with the patient and personally participate in all demanding aspects of the anesthesia plan, even though he may be absent from the operating room at other times to monitor concurrent cases. In particular, the anesthesiologist must be present at induction when the anesthetic is first introduced into the patient at the beginning of the case and at emergence when the surgery has been completed and the patient is being revived from the anesthetic. Moreover, in any event, the anesthesiologist must be present at the end of the case because it is at that time that the anesthesiologist must make a determination as to whether or not the

patient is in sufficiently stable condition to be turned over to a non-anesthesia provider.

53. A second requirement which is required to be satisfied to be reimbursed for medical direction of concurrent procedures is that the anesthesiologist must remain present and immediately available for diagnosis and emergencies. It goes without saying that the anesthesiologist cannot be involved in any other procedures other than the concurrent procedures for which he is billing and must bill the concurrencies correctly. For example, it is improper for bill Medicare for medically directing two procedures if, in fact, the anesthesiologist is involved in four concurrent procedures.

54. Failure to satisfy any of the above requirements disqualifies the anesthesiologist from reimbursement for medical direction and submission of such a bill knowingly or with blind or reckless disregard for its truth constitutes a false claim under the False Claims Act. The defendant anesthesiologists enumerated in the caption to this Complaint have routinely submitted bills to Medicare when they did not satisfy the above requirements.

55. The defendant hospitals, including Abbott Northwestern, St. Cloud, Unity and Mercy have actively assisted the defendant anesthesiologists in submitting those fraudulent bills, abetted their behavior, attempted to conceal the fraud and chill reporting of the fraud by relator's members and, in addition, plaintiffs believe have submitted false claims directly themselves which could have resulted or did result in overpayments by Medicare.

56. The general fraudulent scheme carried out by the defendant anesthesiologists practicing at the defendant hospitals was to provide loose "supervision" of the

CRNAs who were employed by defendant hospitals in a manner which failed to satisfy either the requirements for "medical direction" or for "personal performance", yet to bill Medicare as if they had in many cases "personally performed" the procedure and in other cases, "medically directed" the procedure. The direct consequences of this was that CRNAs' bills submitted on behalf of the CRNAs who actually performed the procedures were not paid at all or were dramatically reduced from the payments to which they were entitled.

57. MANA has further corroborating evidence of defendants' false claims in the form of contemporaneous records that were kept by MANA members. In particular, MANA members Drew Mathews and Charles Hauwiller kept a record and recorded on the patient's anesthesia record over a several year period when defendants left the room and failed to appear for emergence. These records have already been provided to the defendants and are incorporated herein by reference. Kristi Vogt, another MANA member employed at North Memorial Hospital, recorded the defendants' presence or absence at emergence on the anesthesia record. These records are in the possession of defendant Anesthesiology, P.A. and North Memorial Hospital and are incorporated herein by reference. With particularity, the types of fraud engaged in by the anesthesiologists at each of the defendant hospitals was the following.

FALSE CLAIMS ASSOCIATED WITH FAILURE TO PARTICIPATE IN THE MOST DEMANDING PROCEDURES OF THE ANESTHESIA PLAN

58. The defendant MDAs practicing at unity, Mercy and North Memorial Hospitals failed to participate in

either emergence or the most demanding part of the anesthesia plan in virtually every anesthesia procedure performed there in violation of 42 C.F.R. 405.552. Instead, defendants' general practice at those hospitals was to appear for induction at the time that the anesthesia was being provided to the patient, to leave approximately 10 minutes later and to seldom, if ever, return at all. Instead, the CRNA who was the only anesthesia provider left in the operating room, would perform all of the procedures necessary to maintain the patient in the appropriate state of unconsciousness, to bring the patient out of the anesthesia, to extubate the patient when appropriate, and to make the decision whether or not the patient was stable enough to be transferred to a non-anesthesia provider such as the post-anesthesia care unit. For those cases billed as MAC (monitored anesthesia care), it was common practice for MDAs at Mercy, Unity and North Memorial to *never enter the operating room at all*, or only long enough to sign the anesthesia record. While there was some very small percentage of cases in which Unity, Mercy and North Memorial defendants were present at emergence and at extubation a minimum of 95% of the time they were not present as required by Medicare in any Medicare case.

59. The Abbott Northwestern and St. Cloud defendants were present more often at emergence. However, approximately 5% of the time they failed to satisfy this requirement and, nevertheless, improperly billed Medicare for the procedure. Some representative examples of this practice at each of the aforementioned defendant hospitals are the following (Relators can identify the particular patients involved in the vast majority of procedures detailed in this Third Amended Complaint. However,

these names have not been included to protect those patient's confidentiality):

Date of Procedure Associated With False Claim	**Defendant MDA**	**Summary of Procedure**
1. Location Defendant Unity and Mercy		
12/29/93	Albay	Billed for extensive repair of a vagina. The procedure lasted 1 hour and 30 minutes. Contemporaneous records of Drew Mathews demonstrate that defendant Albay was only present for approximately 20 minutes at the beginning of the case and did not return for emergence.
1/12/94	Heil	Billed for medical direction of an operation. Drew Mathews' contemporaneous record shows that Heil was present for only 20 minutes out of a 1 hour 40 minutes operation and was not present at emergence.
2/2/94	Sperry	Billed for medical direction of a case that lasted 1 hour and 10 minutes in connection with surgery to repair a superficial wound. Drew Mathews' contemporaneous record shows that Defendant Sperry was only present for 20 minutes and was not present for emergence.

3/2/94	Magdsick	Billed for an operation in OR-3 at Unity Hospital which began at 7:25 and ended at 9:20. In fact, during this procedure he was attending a meeting with the Critical Care Committee which commenced at 8:00 a.m. and was not available for the emergence of the patient.
3/16/94	Albay	Billed for an operation lasting 1 hour and 10 minutes. Drew Mathews' contemporaneous record shows that Defendant Albay was present only for approximately 15 minutes at the beginning of the case and was not present at emergence.
3/21/94	Jones	Billed for Medically directing three operations when, in fact, he was involved in four concurrent operations. Further, Dr. Jones billed for an operation in OR-7 for which he was only present for 20 minutes out of a 3 hours and 35 minutes hysterectomy operation. Drew Mathews' contemporaneous record shows that he was not present at emergence.

2. Location North Memorial

9/14/95	Everly	Billed for personally performing a case when he was not there at emergence.
11/15/93	Lader	Billed for personally performing a case when he was not there at emergence.

In addition, as previously stated, the North Memorial defendants were absent at emergence approximately 95% of the time in all cases, including Medicare cases. With specificity, plaintiffs allege that in every case in which Kristi Vogt was a CRNA, to the extent she did not note on the medical records that defendant MDAs were present at emergence, they were absent. The dates, times, locations and other relevant information concerning these false claims are within the possession of defendant Anesthesiology, P.A. and North Memorial Hospital. Plaintiff has requested this information but has not yet received it.

3. Location defendant Abbott Northwestern Hospital

12/19/95	Meisner	Failed to participate in emergence in a case performed in the main operating room in the basement of Abbott Northwestern Hospital. Her failure to do so was based upon her involvement in medically directing a case in the minimally invasive unit five floors above.
6/1/95	Engwall	Was responsible for a case at Abbott Northwestern Hospital. Charles Hauwiller was

		the CRNA on the case. Engwall left for lunch and no anesthesiologist relieved him or came into the room after he left. No anesthesiologist was present at the end of the case during emergence. Defendant Engwall was paged several times during the case but failed to appear at the end of the case.
10/5/95	Engwall	Was responsible for a case at Abbott Northwestern Hospital. Charles Hauwiller was the CRNA on the case. Defendant Engwall was at lunch throughout the case and never entered the operating room from the beginning until the end of the case.
3/1/95	Engwall	Was responsible for an anesthesia case in the basement while at the same time taking responsibility for a concurrent case in the minimally invasive center on the fifth floor. Despite being paged twice, defendant Engwall did not return for emergence or extubation. Defendants McKlveen, Skoog, Nissen and Musich were also paged, however, no MDA appeared for emergence of the patient.

Drew Mathews Records

In addition, Drew Mathews recorded on the anesthesia records in scores of instances when MDAs at Unity were not present at emergence. The dates and times of these procedures are on records currently solely in defendants' possession.

4. Location defendant St. Cloud Hospital

8/26/94	McMillan	Started a case at 10:40 a.m. and turned the case over to defendant Rice at 11:56 a.m. The first cased ended at 13:15. Rice started another case at 13:12 and neither McMillan nor Rice were present for the emergence of the patient at the end of the case yet McMillan billed under the AA modifier for personally performing the case.
5/31/90	Gacusana	Was performing an operation at St. Cloud Hospital in OR-1. He billed for personally performing this procedure even though he was also involved in and responsible for a procedure in OR-4 which commenced 1 minute before the procedure in OR 1 and ended 40 minutes after the procedure in OR-1. This bill was fraudulent both on the basis of Gacusana's failure to be present and participate in the most demanding procedures of the anesthesia plan and also on the basis

		that he did not remain in the room with the patient. Medicare rejected the CRNA's bill for the operation in OR-1 on the basis that Defendant Gacusana billed it as "personally performed."
3/18/94	Johnson	Billed Medicare for personally performing a case where he had become ill and leftthe room shortly after induction and never returned. In fact, Defendant Johnson was attached to an IV in the doctors' lounge while this procedure was occurring. Based on the anesthesia record, which was altered by defendant Zwick, no anesthesiologist was responsible for the case between 15:15 and 16:33.
2/4/92	Espelien	Billed for a procedure in St. Cloud Hospital under the AA modifier which began at 10:51 and ended at 13:58. This whole time defendant Espelien billed for an anesthesia procedure which commenced at 12:25 in another operating room and ended at 13:25. The two procedures were concurrent. Moreover, because he was not present in the room the entire time and was, in fact, involved in other procedures, Defendant Espelien did not qualify to bill the procedure as personally performed.

FALSE CLAIMS ASSOCIATED WITH FAILURE TO FULFILL REQUIREMENTS OF PERSONAL PERFORMANCE

60. In addition, the defendant MDAs practicing at St. Cloud, Unity, Mercy, North Memorial and Abbott Northwestern Hospitals were never present in the operating room with the patient and the CRNAs in 1:1 cases for the entire anesthesia time as required by Medicare for any Medicare procedure between January 1988 and June 14, 1996. While their reasons for these absences from the operating room varied including, among others: (1) providing servcies on a time billed basis to other patients; (2) providing services on a fixed fee basis to other patients; (3) sleeping; (4) reading or attending to personal business on the phone; (5) attending meetings or performing duties on other floors; (6) being attached to an IV and receiving fluids in the doctors' lounge; (7) watching Star Trek; (8) watching Vikings football games; (9) leaving the hospital; or (10) engaging in other activities. Their failure to be present with the CRNA and patient for the entire anesthesia service time in these procedures disqualified them from billing for personally performing anesthesia procedures to Medicare. In May 1994 MAPA defendants even discussed adopting a policy whereby they would start cases at one hospital and leave to do cases at the other hospital.

61. In violation of the False Claims Act, the aforementioned defendants nevertheless filed at least 40,000 bills to Medicare under the "AA" modifier claiming that they personally performed procedures between January 1988 and the date of this Third Amended Complaint. The specific dates and time of these procedures is set forth in computer printouts in MANA's possession, as well as in

records maintained by the defendants and by MetraHealth Ins. Co. A summary of many of the bills submitted by each of the defendant anesthesiologists is annexed hereto as Exhibit "A" and incorporated herein by reference. Since the printouts of the individual procedures and billing information in question cover over 250,000 separate bills and instances, they are not annexed to this Third Amended Complaint. However, they are incorporated herein by reference and are available in plaintiffs' counsel's office for review by defendants should they desire to do so. Additional billing information is in the possession of defendants' Medicare carrier. Representative examples of what plaintiffs believe to be fraudulent claims by these defendants based upon their failure to be present with the patient in the operating room for the entire anesthesia time are as follows:

Date of Procedure Associated With False Claim	**Defendant MDA**	**Summary of Procedure**
Location Defendant Mercy Hospital		
6/9/92	Janossy	Defendant Janossy billed Medicare for personally performing a heart case from 8:30 to 23:55. He billed for a *second* Medicare case, which started at 7:35 and ended at 8:50, as though there were two concurrent cases. During the span of the first case he billed *nine* other cases on non-Medicare patients: (1) 9:04 to 9:20; (2) 9:10 to 10:55;

		(3) 9:33 to 11:15; (4) 11:15 to 11:45; (5) 12:45 to 13:35; (6) 12:30 to 17:35; (7) 17:35 to 18:35; (8) 7:48 to 8:45; and (9) 8:45 to 9:00. At 8:45, he was involved in four concurrent cases. Therefore both the first and the second Medicare cases were fraudulently billed.
11/2/89	Baggenstoss:	He billed for personally performing an operation in OR-4 which began at 11:20 and ended at 12:20. However, at the same time, he was also performing a procedure in OR-7 which began at 10:57 and ended at 11:55. Under the rules, these were concurrent procedures and it was fraudulent to bill either one of them as personally performed.
8/21/90	Suh	He billed for personally performing an operation in OR-2 between 18:50 and 21:20 when the records indicate he was also performing an anesthesia procedure in OR-5 between 20:45 and 23:40. These were concurrent procedures and it was fraudulent to bill them as personally performed.

7/2/90	Sperry	He billed for performing an operation in OR-2 which lasted 1 hour and 45 minutes and began at 7:25 and ended at 8:50. However, at the same time, in OR-4, he was involved in an anesthesia procedure which began at 8:05 and ended at 8:20. These procedures are clearly concurrent procedures and billing one or both of them as personally performed was fraudulent.
9/20/89	Baggenstoss	He billed for an operation in OR-3 as personally performed. The operation lasted over 7 hours beginning at 19:15 and ending at 2:30. At the same time, he was performing anesthesia procedures in OR-2 beginning at 18:05 and ending at 19:35 and OR-2 beginning at 20:25 and ending at 21:50. Both of these operations overlap the personally performed operation and, therefore, they should have been billed as concurrent medically directed operations. Billing one or more of them as personally performed was fraudulent.

11/15/89	Baggenstoss	He billed for personally performing an operation which lasted 7.5 hours between 10:30 and 18:15. At the same time, he billed for performing an anesthesia procedure and operating in OR-2 which began at 16:55 and ended at 18:10. These two operations clearly overlapped under the Medicare regulations and billing one or more of them as personally performed is clear fraud.
10/11/89	Jernigan	He billed for personally performing an operation in OR-9. The procedure lasted two hours. It began at 12:30 and ended at 14:25. At the same time, he was billing for an anesthesia procedure in OR-2 which began at 11:50 and ended at 14:30. These two operations clearly overlapped and billing one or more of them as personally performed was clearly fraudulent.
3/7/94	Magdsick	He billed for personally performing an operation in OR-10. The operation lasted 11 hours and 25 minutes and began at 6:35 and ended at 18:00.

		During that same time period, Defendant Magdsick billed for an anesthesia procedure in OR-6 which began at 11:15 and ended at 12:40 and an anesthesia procedure in OR-8 which began at 11:48 and ended at 12:35. The first bill is clearly fraudulent since all of these operations were concurrent. The other two bills may also be fraudulent, however, they have not been provided to us.
3/10/94	Suh	Defendant Suh was performing a catscan and an X-ray between 12:45 and 15:30 and billed for same. At the same time he billed for performing anesthesia procedures in *another part of the hospital* in OR-3, the first procedure beginning at 12:50 and ending at 13:02 and the second procedure beginning at 13:20 and ending at 15:00. Both these procedures were ongoing while Defendant Suh was apparently in another part of the hospital performing a catscan. Clearly he was not present and available to attend to any emergencies that might arise regardless of how he may have billed those procedures.

Location Defendant Unity Hospital

2/7/92	Castillejos	Billed for personally performing a case from 11:00 to 12:05 while at the same time doing another case from 10:20 to 11:20.
10/7/92	Hong	Billed for personally performing a case from 12:25 to 16:00 while at the same time billing for a procedure from 12:15 to 13:05 and from 14:25 to 15:25.
1/24/92	Heil	Billed for personally performing a case from 15:20 to 17:25 while at the same time billing for a procedure from 13:30 to 15:50.
3/28/92	Magdsick	Billed for personally performing a case from 8:15 to 16:20 while at the same time billing for a procedure from 12:20 to 13:35.
11/25/92	Albay	Billed for personally performing a case from 10:25 to 14:45 while at the same time billing for a procedure from 13:30 to 15:15.
2/15/93	Albay	Billed for personally performing a case from 7:35 to 8:30 while at the same time billing for a procedure from 7:30 to 7:45 and from 7:50 to 8:05.
7/19/93	Polta	Billed for personally performing a case from 9:20 to 19:20

		while at the same time billing for a procedure from 7:30 to 11:15 and another case from 11:55 to 12:55.
Location Defendant St. Cloud Hospital		
5/31/90	Gacusana	Gacusana billed for personally performing in this opration in OR-1. It began at 12:35 and ended at 13:03. At the same time, Defendant Gacusana was billing for an operation in OR-4 which began at 12:34 and ended at 13:43. The CRNA's bill for the prior operation was rejected by Medicare. Accordingly, Defendant Gacusana's bill was clearly fraudulent.
2/4/92	Espelien	He billed for personally performing an operation which began at 10:51 and ended at 13:58. Because of this the bill for the CRNA who actually performed the operation, Mary Stotko, was rejected by Medicare. In fact, Defendant Espelien was also billing for an anesthesia procedure in another operating room which commenced at 12:25 and ended at 13:25. Therefore, his bill for the first operation was fraudulent. The

		CRNA in question had to take this matter all the way to a Judge before she was able to obtain a reversal and be paid the modest amount she was owed for actually performing the case.
8/8/91	Gacusana	He billed for an operation in OR-5 which began at 20:40 and ended at 2:12. He billed for personally performing this operation and as a result the CRNA's bill was rejected by Medicare. During the same time Defendant Gacusana was also billing for an anesthesia procedure that began at 21:40 and ended at 23:00 and an operation that began at 23:11 and ended at 00:17. Thus the bill for personal performance was fraudulent and as a result the bill for the CRNA who performed the work was reected by Medicare.
3/29/90	Johnson	Billed for personally performing a case in OR-8 which began at 7:20 and ended at 10:35. At the same time he was also billing for an anesthesia procedure in OR-10 which began at 7:43 and ended at 10:04.

		These operations clearly overlapped and Defendant Johnson's bill was clearly fraudulent. As a result the bill from the CRNA who performed the case was rejected by Medicare.
2/6/90	Johnson	Billed for personally performing an operation in OR-1 which commenced at 12:05 and ended at 14:55. At the same time he was billing for an anesthesia procedure in OR-4 which commenced at 13:45 and ended at 15:50. There is a discrepancy in the times on the chart and the times on the Anesthesia Daily Log. In any event, these operations clearly overlapped. Defendant Johnson fraudulently billed the first operation as personally performed and as a result the bill from the CRNA who actually performed the work was rejected by Medicare.
3/5/90	Rice	He billed for personally performing a case in OR-1 which began at 14:25 and ended at 15:50. This, by the way, is the same patient that Defendant Johnson had previously fraudulently billed.

		At the same time Defendant Rice was billing for anesthesia in OR-2 which began at 12:20 and ended at 15:10. Again there is a discrepancy between the actual times no the anesthesia record and the times on the computerized Daily Log. In any event the two operations clearly overlap. Defendant Rice fraudulently billed the first operation as personally performed and as a result, the bill for the CRNA who actually performed the operation was rejected by Medicare.
1/12/90	Gacusana	He billed for an operation in OR-5 which commenced at 19:15 and ended at 22:00. At the same time he was billing for an anesthesia procedure in OR-3 which commenced at 20:40 and ended at 22:15. Gacusana fraudulently billed for personally performing the first operation although he was concurrently medically directing another operation., As a result, the bill from the CRNA who actually performed the anesthesia procedure was rejected by Medicare.

11/30/89	Halvorson	He was performing an anesthesia procedure in OR-6 which commenced at 7:45 and ended at 11:15 and billed for personally performing same. At the same time he was billing for an anesthesia procedure in OR-7 which commenced at 7:30 and ended at 9:50. As a result of Defendant Halvorson's fraudulent bill for the first operation, the bill for the CRNA who actually performed the procedure was denied by Medicare.
10/31/89	Johnson	Johnson billed for an anesthesia procedure in OR-1 which began at 7:30 and ended at 9:20. He billed for personally performing this procedure although at the same time he was billing for a procedure in OR-7 which began at 6:55 and ended at 8:25. This case was followed by another case in OR-7 which started 8:45 and ended at 10:55. Both cases in OR-7 were concurrent with the procedure in OR-1. Accordingly, Defendant Johnson's bill for the first operation was fraudulent. As a result of his fraudulent bill, the bill from

		the CRNA who actually performed the procedure was rejected by Medicare.
11/8/89	Boyle	Boyle billed for personally performing an operation that began at 9:55 and ended at 11:05. At the same time he was also billing for a concurrent operation which began at 7:50 and ended at 10:45. The bill for the first operation was fraudulent and as a result the bill from the CRNA who actually performed the procedure was rejected by Medicare.
8/25/89	Evenson	Evenson billed for an operation in OR-7 which began at 14:25 and ended at 16:55. At the same time he was billing for an operation in OR-CR which began at 16:45 and ended at 18:10. Defendant Evenson's bill for the first operation was fraudulent. As a result the bill from the CRNA who actually performed the procedure was rejected by Medicare.
7/24/89	Espeland	He billed for an anesthesia procedure in OR-8 which began at 15:20 and ended at 20:50.

		At the same time he was billing for an anesthesia procedure in OR-3 which began at 18:25 and ended at 18:55. The bill for the first procedure was fraudulent and as a result the bill from the CRNA who actually performed the procedure was denied by Medicare.
11/4/93	Zwick	Zwick started at case at 11:04 in OR-11, and turned this case over to Defendant Boyle at 12:36. She was also doing another case from 9:25 - 11:20, yet she billed the case in OR-11 as personally performed.
7/2/94	Rice	Billed Medicare for personally performing, yet was not continuously involved and the CRNA noted "Doctor Rice notified" when cardiac changes occurred.
5/13/94	Boyle	Boyle billed Medicare for personally performing a case in OR-5 from 18:16 to 19:20. Prior to starting this case, he relieved Defendant Johnson on a different case at 17:41 and finished that case at 18:23.
5/30/94	McMillan	McMillan billed Medicare for personally performing a case in OR-5 from 22:55 to 0:49. From 23:15 until 00:01, he was involved in a C-section in delivery room 1 on a different floor.

11/11/93	Boeke	Boeke billed Medicare for personally performing a case from 20:45 to 21:45 in OR-5. He did a different case in OR-18 from 21:45 to 23:06.
8/26/94	McMillan and Rice	McMillan billed Medicare for personally performing a case in OR-6 that started at 10:40. The case was turned over to Defendant Rice at 11:56. The CRNA time shows the case ended at 13:15, but apparently Defendant Rice was not present for emergence, since there is no MDA stop time charted. This seems likely since Defendant Rice started another case in OR-2 at 13:12 and finished it at 15:54. At any rate there were two concurrent cases going on at the same time and he was not allowed to bill for personally performing the case in OR-6.
12/28/94	Lang	Lang billed for personally performing a case in OR-1 from 7:28 to 10:30. He was doing another case in OR-4 from 8:13 to 10:09. The first case was therefore fraudulent. The record was altered to show that Defendant Reitz did the first case.

Location Defendant Abbott Northwestern Hospital

12/16/89	Beverlin and	Drew Mathews record shows this case lasted 2 hours and

	Dwarkanath	20 minutes. Beverlin started the case but was later relieved by Dwarkanath. In total, the two of them were present in the room for 25 minutes. The case was billed as AA.
1/18/95	Boening	Drew Mathews record shows this case lasted one hour. Boening was present for 20 minutes.
6/16/93	Burke	Drew Mathews record shows this case lasted one hour, but Burke was only present for 30 minutes, yet billed for personally performing the case.
12/3/92	Gayes and Burke	Drew Mathews record shows this case lasted 3 hours and 10 minutes. Gayes started the case and was later relieved by Burke. Together the two of them were present for 25 minutes yet billed for personally performing the case.
11/28/95	Gayes	Drew Mathews records shows this case lasted 3 hours and 5 minutes, but Defendant Gayes never entered the operating suite but rather peered through the window of the adjacent ante-room occasionally during the case. He billed for personally performing the case. Clearly this was a non-medically directed CRNA case, and as such should have been billed using the QZ modifier.

		Instead the hospital routinely billed using the QX modifier (medically directed CRNA services) confirming the MDA fraudulent bill, even though this meant Medicare paid nothing or less than they should have for the CRNA services.
1/12/93	Gudman	Drew Mathews record shows this case lasted 2 hours and 35 minutes, but Defendant Gudman was present for only 35 minutes, yet he billed for personally performing the case.
8/13/93	Lillehei	Drew Mathews record shows this case lasted one hour and 18 minutes but Defendant Lillehei was present for only 25 minutes, yet he billed for personally performing the case.
9/1/93	McKlveen and Gudman	McKlveen started this case and was later relieved by Defendant Gudman. Drew Mathews record shows this case listed 8 hours, but Defendant McKlveen and Defendant Gudman were present for only one hour and 45 minutes, yet they billed for personally performing the case.

12/3/92	Menzel and Meisner	Menzel started this case and was later relieved by Defendant Meisner. Drew Mathews record shows this case lasted 3 hours and 30 minutes, but Defendant Menzel and Defendant Meisner were present for only 25 minutes, yet they billed for personally performing the case.
3/26/94	Musich and Lillehei	Musich started this case and was later relieved by Defendant Lillehei. Drew Mathews record shows this case lasted 2 hours and 10 minutes, but Defendant Musich and Defendant Lillehei were present for only 30 minutes, yet they billed for personally performing the case.
7/21/93	Plut	Drew Mathews record shows this case lasted 2 hours and 45 minutes but Defendant Plut was present for only 1 hour and 30 minutes, yet he billed for personally performing the case.
3/23/90	R. Johnson	Drew Mathews record shows this case lasted 2 hours, but Defendant Richard Johnson was present for only 50 minutes, yet he billed for personally performing the case.
10/3/94	Shaw, Boening, Beverlin	Shaw started this case and was later relieved by Defendant Boening, who was in

		turn relieved by Defendant Beverlin. Drew Mathews record shows this case lasted 2 hours and 15 minutes. Defendant Shaw was present for 16 minutes. Defendant Boening was present for 2 minutes. Defendant Beverlin was present for 7 minutes. They billed for personally performing the case.
5/23/95	Stauffer	Drew Mathews record shows this case lasted 2 hours and 40 minutes, but Defendant Stauffer was present for only 40 minutes, yet he billed for personally performing the case.
12/25/93	Wintermute	Drew Mathews record shows this case lasted 2 hours and 30 minutes, but Defendant Wintermute was present for only 1 hour and 5 minutes, yet he billed for personally performing the case.

Location North Memorial Hospital

3/31/91	Lader	Billed for personally performing procedure when he was absent from the room for a substantial period of time.
5/7/91	Walker	Billed for personally performing case when he was not in the room for the entire time.
4/25/91	Atmore	Billed for personally performing a case when he was not in

		the room for a substantial period of the time.
5/30/91	Lader	Billed for personally performing a case when he was absent from the room for a substantial period of time.
4/26/91	Everly	Billed for personally performing a case when he was absent from the room for a substantial period of the time.
5/9/91	Peterman	Billed for personally performing a case when he was absent from the room for a substantial period of the time.
9/27/94	Walker	Billed for personally performing a case when he was absent from the room for a substantial period of the time.
10/3/94	Peterman	Billed for personally performing a case when he was absent from the room for a substantial period of the time.

In addition, plaintiffs have in their possession printouts detailing the defendant, date, procedure, amount paid and other relevant information demonstrating that defendant Anesthesia P.A. during the relevant period submitted approximately 7,000 bills under the AA modifier. Plaintiffs intend to prove that in *all* of these cases, the Anesthesia, P.A. MDAs were absent from the room disqualifying them for reimbursement under Medicare. See Exhibit "A" hereto.

62. Defendent anesthesiologists were not merely momentarily absent from the operating room during the anesthesia procedures described above. Rather, during the relevant time period January 1988 to at least June 1996, it was routine for each of the defendant anesthesiologists to leave the operating room for substantial portions of the time that the procedure was taking place even though they intended to bill and did bill Medicare for personally performing the procedure occurring in the operating room. While the anesthesiologist was absent, it was the CRNA members of plaintiff MANA who actually provided the anesthesia services to the patient.

FALSE CLAIMS BASED UPON WRONG CONCURRENCY

63. The plaintiffs have also billed a substantial number of procedures with the wrong concurrency thereby inducing overpayments from Medicare. Some representative examples are the following:

Location Defendant Northwest Anesthesia

6/21/93	Beverlin	Billed for personally performing a procedure from 9:40 to 14:30 while concurrently involved in a procedure in another case from 7:15 to 10:05.
7/21/93	Beverlin	Billed for personally performing a procedure from 8:30 to 13:05 while concurrently involved in a procedure in another case from 7:15 to 8:55.

9/8/93	Beverlin	Billed for personally performing a procedure from 9:15 to 11:05 while concurrently involved in a procedure in another case from 7:30 to 11:00
11/9/93	Beverlin	Billed for personally performing a procedure from 14:30 to 19:40 while concurrently involved in a procedure in another case from 12:25 to 14:40.
11/25/93	Beverlin	Billed for personally performing a procedure from 10:20 to 18:02 while concurrently involved in a procedure in another case from 9:20 to 11:10.
12/23/93	Beverlin	Billed for personally performing a procedure from 8:30 to 11:40 while concurrently involved in a procedure in another case from 7:30 to 8:30.
7/25/94	Beverlin	Billed for personally performing a procedure from 9:55 to 16:40 while concurrently involved in a procedure in another case from 8:20 to 10:40.
10/3/94	Beverlin	Billed for personally performing a procedure from 12:40 to 15:40 while concurrently involved in a procedure in another case from 11:30 to 13:30.
4/12/95	Beverlin	Billed for personally performing a procedure from 9:25 to 13:00 while concurrently involved in a procedure in another case from 7:40 to 14:40.

5/18/95	Beverlin	Billed for personally performing a procedure from 13:00 to 17:00 while concurrently involved in a procedure in another case from 11:25 to 14:15.
6/1/95	Beverlin	Billed for personally performing a procedure from 9:10 to 12:10 while concurrently involved in a procedure in another case from 8:00 to 10:30.
12/15/95	Beverlin	Billed for personally performing a procedure from 15:20 to 18:10 while concurrently involved in a procedure in another case from 14:20 to 16:05.
8/8/93	Blomberg	Billed for personally performing a procedure from 10:35 to 13:50 while concurrently involved in a procedure in another case from 10:20 to 12:30.
11/11/93	Blomberg	Billed for personally performing a procedure from 14:40 to 19:00 while concurrently involved in a procedure in another case from 13:00 to 14:40.
2/10/94	Blomberg	Billed for personally performing a procedure from 16:05 to 20:30 while concurrently involved in a procedure in another case from 13:10 to 16:20.
11/18/94	Blomberg	Billed for personally performing a procedure from 15:07 to 19:50

		while concurrently involved in a procedure in another case from 14:00 to 15:35.
1/24/95	Blomberg	Billed for personally performing a procedure from 11:03 to 14:10 while concurrently involved in a procedure in another case from 7:35 to 11:30.
2/8/95	Blomberg	Billed for personally performing a procedure from 8:40 to 9:10 while concurrently involved in a procedure in another case from 7:30 to 9:05.
4/20/95	Blomberg	Billed for personally performing a procedure from 10:30 to 14:00 while concurrently involved in a procedure in another case from 8:05 to 10:30.
6/9/95	Blomberg	Billed for personally performing a procedure from 11:20 to 16:10 while concurrently involved in a procedure in another case from 7:40 to 13:15.
10/3/95	Blomberg	Billed for personally performing a procedure from 8:50 to 15:25 while concurrently involved in a procedure in another case from 7:35 to 8:50.
6/24/93	Boening	Billed for personally performing a procedure from 10:25 to 13:30 while concurrently involved in a procedure in another case from 10:00 to 11:45.

8/18/93	Boening	Billed for personally performing a procedure from 9:35 to 14:35 while concurrently involved in a procedure in another case from 7:30 to 9:50.
11/17/93	Boening	Billed for personally performing a procedure from 8:10 to 11:20 while concurrently involved in a procedure in another case from 7:25 to 10:15.
4/6/94	Boening	Billed for personally performing a procedure from 8:30 to 9:50 while concurrently involved in a procedure in another case from 7:15 to 9:00.
7/23/94	Boening	Billed for personally performing a procedure from 12:10 to 13:05 while concurrently involved in a procedure in another case from 7:50 to 12:10.
8/21/94	Boening	Billed for personally performing a procedure from 17:45 to 19:45 while concurrently involved in a procedure in another case from 16:45 to 17:35.
10/11/94	Boening	Billed for personally performing a procedure from 11:55 to 13:15 while concurrently involved in a procedure in another case from 10:50 to 12:22.
1/21/96	Boening	Billed for personally performing a procedure from 21:40 to 0:55 while

		concurrently involved in a procedure in another case from 20:50 to 22:45.
6/16/93	Burke	Billed for personally performing a procedure from 11:35 to 18:50 while concurrently involved in a procedure in another case from 10:35 to 12:10.
6/17/93	Burke	Billed for personally performing a procedure from 10:50 to 12:55 while concurrently involved in a procedure in another case from 10:35 to 12:55.
1/3/94	Burke	Billed for personally performing a procedure from 9:05 to 12:10 while concurrently involved in a procedure in another case from 7:15 to 9:10.
10/17/94	Burke	Billed for personally performing a procedure from 9:35 to 12:55 while concurrently involved in a procedure in another case from 7:30 to 9:35.
10/26/94	Burke	Billed for performing a procedure from 9:10 to 10:35 while concurrently involved in a procedure in another case from 7:35 to 11:30.
10/31/94	Burke	Billed for performing a procedure from 9:55 to 11:35 while concurrently involved in a procedure in another case from 7:30 to 9:55.

11/17/94	Burke	Billed for performing a procedure from 20:50 to 22:30 while concurrently involved in a procedure in another case from 18:45 to 20:50.
2/20/95	Burke	Billed for performing a procedure from 9:12 to 13:20 while concurrently involved in a procedure in another case from 7:45 to 9:45.
9/27/95	Burke	Billed for performing a procedure from 9:50 to 13:12 while concurrently involved in a procedure in another case form 7:40 to 10:45.
7/30/93	Blomberg	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
10/28/94	Blomberg	Billed for personally performing a case from 15:00 to 16:15 when he was involved in a concurrent case from 12:15 to 15:00.
7/4/93	Boening	Billed for personally performing a procedure when she was involved in two concurrent procedures.
7/21/93	Boening	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.
8/9/94	Dwaraka-nath	Billed for performing a procedure from 9:00 to 13:30 while concurrently involved in a procedure in another case from 7:40 to 9:55.

9/8/94	Dwaraka-nath	Billed for performing a procedure from 10:20 to 12:40 while concurrently involved in a procedure in another case from 7:45 to 14:20.
6/16/93	Engwall	Billed for performing a procedure from 13:15 to 15:00 while concurrently involved in a procedure in another case from 13:10 to 13:40.
7/19/93	Gayes	Billed for performing a procedure from 11:45 to 16:45 while concurrently involved in a procedure in another case from 7:10 to 12:00.
7/23/93	Gayes	Billed for performing a procedure from 14:20 to 16:25 while concurrently involved in a procedure in another case from 13:25 to 14:45.
8/25/93	Giron	Billed for performing a procedure from 16:20 to 19:00 while concurrently involved in a procedure in another case from 16:10 to 17:30.
9/2/93	Groves	Billed for performing a procedure from 11:45 to 14:35 while concurrently involved in a procedure in another case from 10:40 to 11:50.
9/7/93	Gudman	Billed for performing a procedure from 9:15 to 11:10 while concurrently involved in a procedure in another case from 9:00 to 11:05.
9/2/93	Johnson	Billed for performing a procedure from 13:55 to 17:45 while concurrently involved in a procedure in another case from 7:00 to 15:30.

10/22/93	Johnson	Billed for performing a procedure from 14:15 and 19:45 while concurrently involved in a procedure in another case from 13:35 to 15:10.
12/8/93	Lilllehei	Billed for performing a procedure from 17:55 to 20:40 while concurrently involved in a procedure in another case from 16:25 to 18:20.
8/5/93	McKlveen	Billed for performing a procedure from 17:45 to 19:45 while concurrently involved in a procedure in another case from 17:00 to 18:15.
9/15/93	Meisner	Billed for performing a procedure from 12:15 to 14:00 while concurrently involved in a procedure in another case from 11:20 to 12:32.
4/29/94	Meisner	Billed for performing a procedure from 8:15 to 10:15 while concurrently involved in a procedure in another case from 8:00 to 9:15.
6/4/93	Menzel	Billed for performing a procedure from 9:50 to 13:30 while concurrently involved in a procedure in another case from 7:25 to 10:50.
10/19/93	Musich	Billed for performing a procedure from 11:45 to 14:45 while concurrently involved in a procedure in another case from 11:00 to 11:55.
10/22/93	Musich	Billed for performing a procedure from 23:00 to 3:30 while concurrently involved in a procedure in another case from 22:30 to 23:55.

8/26/93	Nissen	Billed for performing a procedure from 12:30 to 16:40 while concurrently involved in a procedure in another case from 12:15 to 14:40.
12/22/93	Nissen	Billed for performing a procedure from 15:10 to 17:00 while concurrently involved in a procedure in another case from 14:50 to 16:10.
7/12/93	Pereira	Billed for performing a procedure from 12:00 to 17:30 while concurrently involved in a procedure in another case from 7:35 to 12:25.
8/12/93	Pereira	Billed for performing a procedure from 9:45 to 14:45 while concurrently involved in a procedure in another case from 8:40 to 12:05.
9/9/93	Pereira	Billed for performing a procedure from 11:35 to 14:05 while concurrently involved in a procedure in another case from 10:10 to 16:30.
10/20/93	Pereira	Billed for performing a procedure from 20:10 to 21:55 while concurrently involved in a procedure in another case from 18:05 to 20:40.
8/23/93	Plut	Billed for performing a procedure from 12:25 to 14:55 while concurrently involved in a procedure in another case from 12:25 TO 13:25.
9/2/93	Plut	Billed for performing a procedure from 9:55 to 13:35 while concurrently involved in a procedure in another case from 9:15 to 11:20.

6/25/93	Shaw	Billed for performing a procedure from 8:00 to 8:35 while concurrently involved in a procedure in another case from 7:25 to 9:45.
11/4/93	Shaw	Billed for performing a procedure from 10:40 to 13:50 while concurrently involved in a procedure in another case from 9:40 to 11:15.
10/4/93	Skoog	Billed for performing a procedure from 18:20 to 23:05 while concurrently involved in a procedure in another case from 17:45 to 19:25.
10/28/93	Skoog	Billed for performing procedure from 10:00 to 16:45 while concurrently involved in a procedure in another case from 8:45 to 12:15.
7/21/93	Stauffer	Billed for performing a procedure from 11:00 to 12:15 while concurrently involved in a procedure in another case from 9:45 to 11:05.
11/5/93	Tiu	Billed for performing a procedure from 9:45 to 14:15 while concurrently involved in a procedure in another case from 7:20 to 10:15.
3/2/94	Tiu	Billed for performing a procedure from 10:25 to 14:20 while concurrently involved in a procedure in another case from 9:45 to 11:00.
8/6/93	Tronnier	Billed for performing a procedure from 17:00 to 21:45 while concurrently involved in a procedure in another case from 13:15 to 19:00.

6/22/93	Wintermute	Billed for performing a procedure from 11:10 to 15:00 while concurrently involved in a procedure in another case from 7:00 to 13:20.
3/21/94	Wintermute	Billed for performing a procedure from 11:30 to 14:20 while concurrently involved in a procedure in another case from 7:15 to 11:40.

Location Defendant Mercy Hospital

3/6/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/12/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/12/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/25/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/25/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/26/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.

3/11/92	Magdsick	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/18/92	Magdsick	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/25/92	Magdsick	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/17/92	Kloepper	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
1/14/92	Yue	Started a Medicare case at 10:50 and finished it at 11:50. The case was billed as though there were two concurrent cases, but he was involved in other cases from 11:30 to 12:30 and from 10:55 to 11:30.
3/18/92	Yue	Started a Medicare case at 9:05 and finished it at 10:20. The case was billed as though there were two concurrent cases but he was involved in other cases from 8:30 to 9:25, and from 8:40 to 11:30.
3/18/92	Yue	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.

3/23/92	Yue	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/23/92	Yue	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/25/92	Albay	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.
3/31/92	Janossy	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
1/28/92	Roseberg	Started a Medicare case at 12:07 and finished it at 13:10. The case was billed as though there were two concurrent cases, but he was involved in other cases from 11:45 to 14:15 and from 12:20 to 14:10.
3/6/92	Polta	Started a Medicare case at 7:30 and finished it at 11:20. The case was billed as though there were two concurrent cases, but he was involved in other cases from 7:35 to 8:00 and from 7:30 to 8:25.
3/30/92	Cumming	Started a Medicare case at 7:25 and finished it at 11:45. The case was billed as though there were two concurrent cases, but he was involved in other cases from 9:10 to 10:35 and from 7:30 to 11:45.

4/12/93	Baggen-stoss	Started a Medicare case at 11:55 and finished it at 15:00. The case was billed as though there were two concurrent cases but he was involved in other cases from 13:15 to 14:25, from 13:55 to 17:15 and from 14:50 to 17:20.

Location Defendant Unity Hospital

8/18/92	Albay	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.
9/24/92	Sperry	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
9/25/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
10/7/92	Hong	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
11/30/92	Albay	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
12/15/92	Heil	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.

7/23/92	Castillejos	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.
6/11/92	Castillejos	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.

Location Defendant St. Cloud Hospital

11/3/93	Espelien	Billed QK indicating a concurrency of two for a case in OR-8 from 7:18 to 10:19. At the same time he was doing one case in OR-9 from 7:24 to 12:11 and another in OR-4 from 9:16 to 11:17. These cases should have been billed as a concurrency of three.
5/12/94	Reitz, Boyle, Halvorson	Reitz started a Medicare case in OR-9 at 7:40. At 9:00 he was relieved by one of his partners – either Boyle or Halvorson finished the case at 10:07. Initially the chart said Boyle took over the case, but the chart was altered to read that Halvorson took over the case instead. Boyle did other cases from 7:49 to 10:05 and from 9:15 to 9:40. Halvorson did other cases from 7:26 to 9:55 and from 10:03 to 11:44. Regardless who relieved Reitz, there were three concurrent cases, yet it was billed under Reitz's name as though there were only two concurrent cases.

5/6/94	Reitz, Boyle	Reitz started a Medicare case in R-4 at 7:51. At 11:26 Boyle took over the case and finished it at 12:02. Reitz was doing other cases from 7:25 to 10:30 and from 8:55 to 9:00. The case was billed under Reitz's name as though there were two concurrent cases, but in fact there were three.

FALSE CLAIMS ASSOCIATED WITH PAIN MANAGEMENT

64. In addition to the specific instances of fraud discussed above anesthesiologists practicing at St. Cloud, Unity, Mercy, North Memorial and Abbott Northwestern Hospitals have submitted false claims in connection with post-operative epidurals. Under Medicare regulations in force since at least 1992, anesthesiologists were not permitted to bill for epidurals which were performed during a general anesthesia and under no circumstances were they permitted to bill for daily management of an epidural on the date of the surgical procedure. In fact, the defendant anesthesiologists at St. Cloud Hospital, Unity and Mercy Hospitals violated this restriction and, nevertheless, submitted bills to Medicare. Between 1992 and the date of this Third Amended Complaint, it has been St. Cloud anesthesiology defendants' common practice to improperly stop the anesthesia time on the anesthesia record while the patient is still under anesthesia and the surgery has not yet been completed in order to place a post-operative epidural catheter. The purpose of stopping the anesthesia time on the record is to deceive Medicare into believing that the anesthesia procedure ended before the post-operative epidural was placed so that the doctor

may bill separately for the more expensive post-operative epidural. Between 1992 and the date of this Third Amended Complaint, defendants have on a number of occasions filed claims with Medicare which were improper and constituted false claims in connection with post-operative epidurals. In particular, by way of representative example, defendants filed the following claims on the following dates:

Date of Procedure Associated With False Claim	Defendant MDA	Summary of Procedure
Cases Billed Where The MDA Stopped The Anesthesia Time In Order To Separately Bill For Placement Of An Epidural		
Location Defendant St. Cloud Hospital		
11/2/93	Rajala	Rajala billed for personally performing a Medicare case in OR-5 from 7:40 to 14:40. The case was not finished until 15:05, but Defendant Rajala ended her time early in order to bill separately for placing an epidural catheter for post operative pain management. Since, by her own record, she was not involved in administering the general anesthetic of this case for the last 25 minutes, and did not participate in emergence, she was not entitled to bill for this case. In addition, she did the pre-operative evaluation of a patient for a case that started in OR-3 at 1330,

which would disqualify her from billing using the AA modifier.

		ACTUAL ANESTHESIA TIME	MDA TIME ABORTED TO BILL FOR EPIDURAL
5/1/93	Espelien	08:01-10:40	08:01-10:15
6/1/93	Lang	09:34-11:12	19:34-11:05
12/20/93	Zwick	07:26-10:50	17:26-10:29
12/29/93	Espelien	09:49-12:58	19:49-12:40
12/16/93	Boyle	09:38-12:10	09:38-11:45
12/16/93	Boeke	17:58-21:11	17:58-20:45
12/1/93	McMillan	09:20-13:20	09:30-12:58
12/1/93	Zwick	07:24-11:47	07:24-11:29

Other Cases Involving Improper Bills For Epidural Anesthesia

3/17/93	Boeke	Charged for more than four days of epidural management.
3/18/93	Boeke	Charged for more than four days of epidural management.
2/17/95	Boeke	Charged for more than four days of epidural management.
2/18/95	Boeke	Charged for more than four days of epidural management.
2/19/95	Boeke	Charged for more than four days of epidural management.

5/3/94	Boyle	Charged for more than four days of epidural management.
5/4/94	Boyle	Charged for more than four days of epidural management.
5/29/94	Boyle	Charged for more than four days of epidural management.
7/7/93	Boyle	Charged for more than four days of epidural management.
7/8/93	Boyle	Charged for more than four days of epidural management.
7/9/93	Boyle	Charged for more than four days of epidural management.
11/22/95	Boyle	Charged for more than four days of epidural management.
1/6/95	Espeland	Charged for more than four days of epidural management.
8/23/94	Espeland	Charged for more than four days of epidural management.
4/3/95	Espeland	Charged for more than four days of epidural management.
4/4/95	Espeland	Charged for more than four days of epidural management.
4/5/95	Espeland	Charged for more than four days of epidural management.
8/5/92	Espelien	Charged for more than four days of epidural management.
8/6/92	Espelien	Charged for more than four days of epidural management.

8/7/92	Espelien	Charged for more than four days of epidural management.
8/8/92	Espelien	Charged for more than four days of epidural management.
8/9/92	Espelien	Charged for more than four days of epidural management.
11/23/94	Espelien	Charged for more than four days of epidural management.
12/26/92	Evenson	Charged for more than four days of epidural management.
11/22/92	Evenson	Charged for more than four days of epidural management.
11/23/92	Evenson	Charged for more than four days of epidural management.
7/11/94	Gacusana	Charged for more than four days of epidural management.
12/2/95	Halvorson	Charged for more than four days of epidural management.
12/3/95	Halvorson	Charged for more than four days of epidural management.
12/4/95	Halvorson	Charged for more than four days of epidural management.
12/14/94	Halvorson	Charged for more than four days of epidural management.
6/22/94	C. Johnson	Charged for more than four days of epidural management.
12/6/95	C. Johnson	Charged for more than four days of epidural management.

12/7/95	C. Johnson	Charged for more than four days of epidural management.
12/8/95	C. Johnson	Charged for more than four days of epidural management.
12/9/95	C. Johnson	Charged for more than four days of epidural management.
12/10/95	C. Johnson	Charged for more than four days of epidural management.
12/11/95	C. Johnson	Charged for more than four days of epidural management.
12/12/95	C. Johnson	Charged for more than four days of epidural management.
12/13/95	C. Johnson	Charged for more than four days of epidural management.

In addition to the above representative examples, plaintiffs have a printout of approximately 87 pages listing similar claims by the St. Cloud defendants.

Defendant Anesthesia P.A.

4/1/92	Pizzaro	Charged for more than four days of epidural management.
4/7/93	Hoffman	Charged for more than four days of epidural management.
4/8/93	Hoffman	Charged for more than four days of epidural management.
9/6/92	Mazur	Charged for more than four days of epidural management.
1/20/92	Lader	Charged for 2 epidurals on the same day.

2/5/93	Lader	Charged for 2 epidurals on the same day.
8/4/93	Schultz	Charged for more than four days of epidural management.
8/5/93	Schultz	Charged for more than four days of epidural management.
8/6/93	Schultz	Charged for more than four days of epidural management.
8/7/93	Schultz	Charged for more than four days of epidural management.
8/8/93	Schultz	Charged for more than four days of epidural management.
8/9/93	Schultz	Charged for more than four days of epidural management.
3/11/95	Schultz	Charged for more than four days of epidural management.
3/12/95	Schultz	Charged for more than four days of epidural management.
3/13/95	Schultz	Charged for more than four days of epidural management.
3/14/95	Schultz	Charged for more than four days of epidural management.
3/15/95	Schultz	Charged for more than four days of epidural management.
9/4/93	Mont-gomery	Charged for more than four days of epidural management.
9/5/93	Mont-gomery	Charged for more than four days of epidural management.
8/30/93	Wright	Charged for more than four days of epidural management.

Defendant MAPA

8/12/92	Baggen-stoss	Charged for more than four days of epidural management.
8/14/92	Baggen-stoss	Charged for more than four days of epidural management.
8/15/92	Baggen-stoss	Charged for more than four days of epidural management.

DEFENDANT HOSPITALS' FRAUDULENT CONDUCT

65. The defendant anesthesiologists' general practices described above were based not on the interest of the patient or quality of care, but rather on maximizing defendant anesthesiologists' profits. For example, during the past six years the defendant anesthesiologists were invariably present for relatively simple billable procedures, such as placement of epidurals or arterial lines, but as set forth herein, are routinely absent for more crucial procedures such as (1) intubations (including emergency intubations), extubations in general anesthesia cases (in the case of Unity, Mercy and North Memorial anesthesiologists); (2) dosing and managing epidurals in labor cases; and (3) intubating and managing airways in trauma cases which are non-billable or have relatively low reimbursement value.

66. Furthermore, the defendants' practice of leaving the operating room for substantial periods of time is not motivated simply by the increased income that their false billing generates from Medicare, but also by the substantially increased compensation they can earn by improperly concurrently performing non-Medicare procedures which pay at a substantially higher rate. Indeed, Relator's

members have been informed by at least two separate individuals familiar with anesthesia billing practices that it would be impossible for the defendant anesthesiologists to obtain the annual compensation they make if they were, in fact, fulfilling the billing requirements of Medicare and accurately billing Medicare. At the defendant hospitals Medicare accounts for between 20%-30% of the procedures performed. Some of these procedures are lengthy and complex procedures such as open-heart procedures and craniotomies lasting up to 8 or 10 hours. If the defendant anesthesiologists actually performed those procedures as they have represented to Medicare they would be precluded from billing for any other procedure during that time period. In fact, as set forth herein, the defendant anesthesiologists in almost every case are involved in others activities, in many cases billable activities, at the same time as they have represented to Medicare that they are personally performing heart procedures, craniotomy procedures and other lengthy and complex procedures. As a result, plaintiffs are informed and believe that the defendant MDA anesthesiologists have obtained compensation far in excess of the national average and, in some cases, in excess of $500,000 per year. It is in order to maintain this improperly high level of compensation that the defendants have gone to the lengths that they have as described in this complaint to preserve their ability to submit false claims and to punish and chill the Relator's members who have sought to prevent or curb their fraudulent practices.

67. In addition to knowingly and actively aiding, abetting and facilitating defendant anesthesiologists' submissions of false claims and knowingly causing the Government to pay claims grounded in fraud as set forth

elsewhere herein and in the case of Unity and Mercy Hospitals profiting directly from that fraud, MANA is informed and believes that the defendant hospitals have themselves submitted false, misleading and inaccurate bills to Medicare which have resulted in overpayments by Medicare. In particular, in cases of medical necessity, defendant Abbott Northwestern, defendant Unity and Mercy and defendant St. Cloud have submitted bills seeking 100% reimbursement from Medicare on the basis that it was medically necessary for *both* a CRNA and an anesthesiologist to be involved in the case. Although the information concerning anesthesia time and services provided given to the hospital by the CRNAs was accurate, the hospitals billed the case under an improper modifier. As a result, Medicare paid both providers 100% of their qualified fee. In fact, in these cases the hospital knew that the anesthesiologists did not personally perform the case and that, in fact, there were not two providers involved in the case. Had the hospital correctly billed Medicare and advised the hospital that the doctors were not personally performing their cases, Medicare would only have been required to pay approximately 50% of the fee it actually paid. The hospitals also failed to bill for non-medical direction of a CRNA when there was either no MDA participation (cardioversions and MAC cases) or for participation which failed to meet minimal medical direction or personal performance requirements. To facilitate the inaccurate billings hospital medical records departments at Unity and Mercy would flag anesthesia records not signed by MDAs and required co-signing after the fact. This inaccurately led Medicare to assume participation by anesthesiologists and incorrectly identified the anesthesiologist billing for the procedure. Some representative examples at the defendant hospitals are the following:

Date of Procedure Associated With False Claim	Defendant MDA	Summary of Procedure Demonstrating MDA's Absence
Location Defendant Abbott Northwestern		
5/9/93	Dwarkanath	Drew Mathews record shows this open heart case lasted 3 hours and 15 minutes, but Defendant Dwarkanath was present for only one hour and 50 minutes, yet he billed for personally performing the case.
6/15/93	Lillehei	Drew Mathews record shows this case lasted 5 hours, but Defendant Lillehei was present for only 3 hours, yet he billed for personally performing the case.
3/3/93	Pereira	Drew Mathews record shows this case lasted 5 hours and 30 minutes, but Defendant Pereira was present for only 2 hours, yet he billed for personally performing the case.
1/25/90	Skoog and Meisner	Skoog started this case and was later relieved by Defendant Meisner. Drew Mathews record shows this case lasted 6 hours and 30 minutes, but Defendant Skoog and Defendant Meisner were present for only 4 hours and 5 minutes, yet they billed for

		personally performing the case.
11/12/92	Tiu	Drew Mathews record shows this case (repair of an aortic aneurysm) lasted 4 hours, but Defendant Tiu was present for only 1 hour and 20 minutes, yet he billed for personally performing the case.
10/1/90	Tronnier	Drew Mathews record shows this open heart case lasted 4 hours and 20 minutes, but Defendant Tronnier was present for only 2 hours and 30 minutes, yet he billed for personally performing the case.
6/22/93	Wintermute	Drew Mathews record shows this open heart case lasted 3 hours and 20 minutes, but Defendant Wintermute was present for only 1 hour and 45 minutes, yet he billed for personally performing the case.

Location Defendant Mercy Hospital

5/19/94	Sperry	Defendant Sperry billed for personally performing the anesthesia for placement of an arteriovenous shunt that started at 12:05 p.m. and ended at 1:30 p.m. Defendant Sperry was doing other cases as follows: (1) 12:50 p.m. to 2:15 pm.; (2) 9:45 a.m. to 3:08

		p.m.; (3) 1:15 p.m. to 2:30 p.m.; and (4) 1:10 p.m. to 2:10 p.m. At 1:30 p.m. Defendant Sperry was involved in five concurrent cases and was not entitled to bill for either performing or medically directing the case. He could have billed for medical supervision and received a fee appropriate for his involvement. In addition, this simple procedure is not among the CPT codes accepted by the local Medicare carrier as "medically necessary" for two providers. This case occurred after CRNAs were forced to subcontract with the anesthesiologists if they wanted to still work at Mercy Hospital. Health Billing Systems submitted both Defendant Sperry's bill for personally performing the case and a bill for the subcontracted CRNA's services.
Location Defendant Unity Hospital		
8/19/94	Eggen	Billed for personally performing a case from 11:45 a.m. to 1:55 p.m. while performing a case from 1:30 p.m. to 3:00 p.m. Health Billing Systems submitted a bill for Defendant Eggen using the AA modifier and a CRNA bill for the same case.

9/20/94	Ryberg	Billed for personally performing a case from 11:35 a.m. to 1:55 p.m. while performing a case from 10:50 a.m. to 12:25 p.m. Health Billing Systems submitted a bill for Defendant using the AA modifier and a CRNA bill for the same case.
9/27/94	Maggs	Billed for personally performing a case from 11:25 a.m. to 2:15 p.m. while performing another case from 1:25 p.m. to 3:00 p.m. Health Billing Systems submitted a bill for Defendant Maggs using the AA modifier and a bill for the CRNA subcontractor for the same case.

Information regarding defendant St. Cloud is not in MANA's possession. However, plaintiff is informed and believes, based upon its members' knowledge of billing practices at that hospital, that similar bills were submitted by the hospital for medical necessity where MANA members know there were not two anesthesia providers present for the entire procedure. The specific dates and patients' names will appear on those bills which are currently only in defendant St. Cloud's possession.

CONDUCT EVIDENCING FRAUDULENT INTENT

68. The defendant hospitals and anesthesiologists defendants have engaged in conduct in furtherance of the above-referenced fraud for purposes of either concealing

the fraud or perpetuating it. Examples of this conduct include:

(1) On a substantial number of occasions, MAPA defendants at Unity and Mercy Hospitals changed circles on the anesthesia record which correctly reflected the concurrency of the cases they were billing to a lower number which misrepresented the true concurrency of the case.

(2) It was a frequent practice for the call MDA to go through previous days records and make changes to the circles.

(3) Defendant Castillejos was seen circling numbers on stacks of anesthesia records at the end of the day which had not been circled by the anesthesiologist in charge of the case. Defendant Magdsick on a number of occasions was seen by Annette Atchison to circle concurrency the following day on cases by other MDAs. On information and belief defendant Castillejos and Magdsick had no knowledge that the circles that they were entering were accurate. This was further confirmed when defendant Heil stated to a Unity CRNA, Maureen Merriam, that defendant Al Tank, MAPA's billing person, said they should be billing a lot more 1:1 and stated to Marie Parvie, one of the Mercy CRNAs, that defendant Al Tank had told her that they were "entitled to bill" about 50% of their cases 1:1. Castillejos also stated to Maureen Merriam that Al Tank was "upset" because Catillejos was not circling enough cases as 1:1.

(4) The MAPA defendants made no attempt to put times on electroconvulsive therapy or pain management records thereby precluding Medicare from determining whether their involvement in those procedures would

have disqualified them from billing Medicare for personally performing concurrent procedures.

(5) Defendant Sperry stated to Maureen Merriam that Medicare will not penalize me "if I do a small case during a 1:1 and bill Medicare for personally performing a 1:1.

(6) In or about April 1991 or 1992 on a weekend in connection with *four* consecutive fractured hip cases for Medicare patients, defendant Rydberg circled a 1 on each record although he was not in the operating room for the majority of the procedure and was, in fact, up in OBGYN on another floor giving epidurals or engaged elsewhere in the hospital. The specific date and times of these false claims can be determined by reviewing the billing records for the relevant period which are exclusively in defendants' possession at this time.

(7) Defendant Craig Johnson at St. Cloud and defendants Mark Sperry and John Magdsick at Unity and Mercy and defendant Mark Nissen at Abbott Northwestern all stated at different times that they did not intend to lose a single penny as a result of changing reimbursement policies and would take whatever steps were necessary to ensure that this occurred.

(8) Defendant Al Tank stated on repeated occasions to CRNAs, including to Fred Benjamin, Mary Buchman, Faye Leatherman, Kaye Vaske and others that he kept multiple sets of books, one for the government, one for the hospital and one for the doctors. Al Tank also told MANA member Fred Benjamin that he had a special way of billing that nobody else could do which would maximize the anesthesiologists' bills. Defendant Sperry told Annette Atchison, CRNA they had special ways of hiding the

profits made by CRNAs, and told Mary Jo Krauel he was going to have to remember which lies he told to whom. Defendant Al Tank made no attempts to confirm whether the anesthesiologist doctors for which he was submitting bills were following Medicare regulations. MAPA defendants made no attempt to determine whether or not their billing persons, Al Tank and Carol Kolbinger, were appropriately following Medicare regulations.

(9) The MAPA defendants, despite the use of an expensive software program to determine concurrencies, consistently submitted incorrect bills to Medicare between 1992 and 1994 resulting in most cases in over payments to MAPA. When the law was changed in January 1994 to provide that supervising additional concurrent procedures would not reduce the anesthesiologist's fee, these errors decreased substantially.

(10) Ladonna Schweer and Terry Rozinka repeatedly asked to see Medicare Denials at Unity and Mercy to appeal those which were incorrect, but the hospitals refused to allow the CRNAs to review them. When Chuck Hauwiller and Drew Mathews began documenting MDA presence in the room during a case, they received a warning from the hospital and the defendants MDAs to stop.

(11) Even though CRNAs at St. Cloud, Unity, Mercy and Abbot Northwestern presented records to each of those defendant hospitals showing not only that the doctors were not present at key times during procedures they had billed but, in fact, that those doctors were in other operating rooms. The hospitals refused to seek a change in the practice of the doctors in their hospitals or to directly address the doctors' proven fraudulent billing.

(12) At all times, defendant hospitals have been or should have been aware that defendant anesthesiologists were presenting false claims to Medicare. Rather than taking steps to prevent the fraud, however, Defendant hospitals have knowingly aided, abetted and facilitated it.

(13) In 1990, Faye Leatherman confronted one of the MDAs who was circling the wrong number for concurrencies on the anesthesia record, she was told to mind her own business.

(14) Between 1990 and 1994, Bart Barry, a CRNA hospital employee, was circling the correct concurrencies on the anesthesia records in which he was involved. He was told by both defendant Sperry and defendant Janossy to stop circling the numbers.

(15) Ladonna Schweer told Judy Haviland and John Murphy, both Operations Vice Presidents of Unity and Mercy, and Dan Roach, corporate counsel, that the Unity and Mercy anesthesiologists were not personally performing cases and were billing for cases when they were in other operating rooms. The hospital took no steps to stop this practice.

(16) Lisa Citak, a CRNA at Abbott Northwestern, repeatedly reported that the doctors were fraudulently billing to hospital personnel but received no response other than blanket denials that fraudulent billing was occurring.

(17) At defendant St. Cloud, Sandra Henschke, Jerry Boldon and other CRNAs reported directly their belief that the defendant doctors were fraudulently submitting bills since the CRNAs were performing the services

and the doctors were in other operating rooms. St. Cloud Hospital took no action to address this fraud.

(18) John O'Konek, a CRNA at Unity, and Bart Barry, a CRNA at Mercy, observed on a number of occasions defendant anesthesiologists in the hospital were covering four to five concurrent procedures. The specific times and dates of these procedures are not available at this time but can be discovered through review of the appropriate anesthesia records in possession of the defendants. It was a common practice for anesthesiologists to start cases and turn them over to MDAs who were already responsible for 2-3 room. Documentation on the anesthesia record or billing, did not reflect these changes.

(19) In a case involving Faye Leatherman when she was a student at Abbott Northwestern, defendant Pereira left Leatherman alone in the room with an extremely difficult heart surgery. Leatherman paged Pereira on multiple occasions and Pereira failed to respond. Later when the patient was taken to PACU a comment was made by the PACU nurse when she learned that Pereira had failed to respond that the patient must have been a Medicare patient. Chuck Hauwiller repeatedly paged for assistance with a patient who was hemorrhaging, but defendant Rick Johnson failed to respond. In a recent case at Abbott Northwestern, Pereira followed his general practice of failing to frequently monitor the case and failing to respond to pages. As a result of Pereira's failure to respond to pages, his giving inappropriate telephone orders given without being present to assess the patient, and creating an environment where CRNAs are restricted, the patient died. This incident, unbeknownst to MANA or its members, was reported by a non-CRNA to the Department of Health. The Department of Health independently

investigated the incident on behalf of HCFA and concluded that Abbott Northwestern was deficient in several areas of anesthesia, including: 42 C.F.R. 482.12(a) Medical Staff (A022), 42 C.F.R. 482.21(a) Clinical Plan (A054); 42 C.F.R. 482.52(a) Organization and Staffing (A264); 42 C.F.R. 482.52(b) Delivery of Services (A279). In connection with these findings, HCFA noted (a) it was reported and verified by interview that some anesthesiologists failed to appropriately respond to their pagers; (b) that delay of reviews of quality assurance matters in the anesthesia department for five months were not unusual; (c) that student registered nurse anesthetists were allowed by the hospital and the MDAs to provide anesthesia without being under the direct supervision of a CRNA or an MDA; (d) that a record review revealed at least two occasions where the only signature of an anesthesia provider on the record was a student anesthetist; (e) that an MDA interviewed by HCFA admitted that he routinely responded late to pages to the PACU; and (f) that documentation revealed that the MDA defendants in this case did not always assist with the transport of ASA-4 patients to the PACU.

The foregoing findings corroborate the allegations of this complaint and demonstrates the hospital's unwillingness to address concerns brought to its attention by the CRNAs. Further proof of the hospital's complicity in this fraud is its attempt to cover up the investigation by intimidating CRNA witnesses and attempting to blame the whole incident on the CRNAs involved rather than investigating and appropriately sanctioning the MDA responsible for the case.

(20) At Abbott Northwestern, defendant Boening, twice in the space of a month, left a patient unattended in a surgery with no CRNA and no MDA present.

On the first occasion, defendant Boening relieved a CRNA responsible for the case and told her to go to lunch and then Boening left the room. The CRNA discovered Boening outside the operating room when she returned from lunch. In the second case, the CRNA was Curt Pascoe. Boening instructed him to go obtain medication from a locked medicine cabinet. When Pascoe returned, Boening was sitting talking on the telephone outside the operating room and there was no anesthesia provider in the room with the patient and the surgeon.

(21) Defendant Albay was discovered sleeping during a case by Fred Benjamin, the CRNA involved with the case. Defendant Baggenstoss appeared to have been sleeping during a case involving Bart Barry.

(22) Maureen Merriam repeatedly observed that MDAs were sleeping at night during cases for which she was the responsible CRNA and yet marking that they personally performed the case on the record.

(23) In a case involving Bart Barry, on which defendant Maggs was the responsible anesthesiologist which occurred during the relevant time period to the complaint, Maggs was watching a movie and did not respond when paged by Barry. Maureen Merriam was unable to get defendant Maggs to respond to an unstable patient because he was on the phone with his wife about a charity ball.

(24) Many of the anesthesiologists at Unity and Mercy Hospital owned beepers but intentionally did *not* carry them with them when they were at the hospital. In 1993, Bart Barry twice stat paged defendant Roseberg to

the OR and never responded. Annette Atchison paged defendant Magdsick several times at the surgeons request and he did not respond. Defendant Suh did not respond to a page from Bart Barry when his patient undergoing heart surgery was coming off bypass. A patient which defendant Castillejos was responsible for died in the preoperative holding area while she was in the Doctor's Lounge next door. Because of this reported lack of response, Ladonna Schweer raised the issue that the Unity and Mercy MDAs do not carry beepers but the hospital refused to require them to do so.

(25) CRNAs at Mercy, Abbott Northwestern, St. Cloud and North Memorial were told by the defendant anesthesiologists that it was the general practice for anesthesiologists at those hospitals to bill heart cases on a 1:1 basis. At Abbott Northwestern an inordinately large percentage of the cases performed are heart cases. In 1994, as a result of what they perceived to be changes in Medicare billing reimbursement policies, the Abbott Northwestern MDAs unilaterally announced that they were going to take over four of the eight operating rooms reserved for hearts and would refuse to allow CRNAs to be involved in those cases. This decision was admitted to be based solely upon economics and was unrelated to quality of care concerns.

(26) In fact, after they assumed control over the heart rooms, the defendant anesthesiologists utilized student nurse anesthetists to perform procedures in those rooms and continued routinely to leave the room, leaving the only anesthesia provider in the room an inexperienced student CRNA.

(27) None of the anesthesiologist defendants documented the services they were providing in an appropriate manner to satisfy Medicare regulations. In particular, none of the anesthesiologists signed in and out of the room when they left the room; none of them documented on the anesthesia chart that they had personally participated in emergence; they very rarely documented when another anesthesiologist assumed the case or relieved them on a case; and they failed to appropriately document concurrent procedures performed by them during Medicare cases. At best, the foregoing showed a complete disregard for the Medicare billing requirements and the needs of their patients. At worst, the foregoing demonstrates an intentional and organized effort to deceive Medicare and to provide Medicare and relator of appropriate records to prove defendants' fraudulent conduct.

HARASSMENT AND INTIMIDATION OF CRNAS WHO REPORTED THE FRAUD OR ASSISTED THIS ACTION

69. The False Claims Act specifically provides for protection for CRNAs who report false claims or assist in prosecution of a false claims action. Following are examples of attempts to intimidate the principal witnesses in the case against the defendants and further demonstrate defendant anesthesiologists' and hospitals' complicity:

a. When defendant Boeke was personally served with a copy of the Summons and Complaint in a related antitrust action alleging fraud on behalf of the doctors, he stated referring to the plaintiffs in the case, "They're dead, they're dead."

b. Plaintiff Ladonna Schweer has had both the passenger window of her car shattered and the hood of her car dented while it was parked in the Unity and Mercy parking lot. These actions occurred subsequent to defendant John Murphy requesting that security provide him with the identify of and license plate number of Ladonna Schweer's car.

c. An unknown individual illegally entered into the locker of Steve Milliken, a CRNA who has provided evidence in connection with this case, and cut the tongue of out of one of his shoes. On information and belief the only individuals who would have access to the identity and combination of Steve Milliken's locker would be the defendant MDAs or the defendant Abbott Northwestern Hospital.

d. CRNA Lisa Citak who reported fraud at Abbott Northwestern was approached by defendant Meredith during an anesthesia procedure who made veiled threats about Citak's ability to support her husband (who is severely ill) and family if the plaintiffs continued to pursue this lawsuit.

e. Anesthesiologists at various of the defendant hospitals made statements to CRNAs to the effect that by pursuing reimbursement for billing for anesthesia procedures the CRNAs had stuck their heads out of a fox hole and were getting them shot off. This was specifically said by Defendant Baggenstoss to Ladonna Schweer at Unity and Mercy Hospital, then by defendant Sperry to John O'Konek and by defendant Kleopper to Maureen Merriam.

f. When Ladonna Schweer complained about the MAPA defendants' fraudulent billing to officers at Unity and Mercy Hospitals, she was repeatedly told to "remember

where your paycheck comes from." This statement was specifically made to her by John Murphy, Operations Vice President of Unity and Mercy Hospitals.

g. When the MDAs learned that Chuck Hauwiller, a CRNA at Abbott Northwestern, was recording when they were absent from the operating room and absent at emergence, defendant Johnson, President of defendant Northwest Anesthesia, wrote a memo instructing him to stop doing so. When he refused to do so, the hospital, in complicity with the MDAs, called Hauwiller into a meeting where direct and indirect threats to his employment were made if he did not stop making notations on the anesthesia record.

70. Among other things, Defendant hospitals have knowingly (1) permitted defendant anesthesiologists to bill in a manner which impedes discovery of their false claims; (2) refused to require defendant anesthesiologists to sign in and out of operating rooms; (3) In the case of Unity and Mercy, refused to require defendant anesthesiologists to carry "pagers"; (4) ignored and discouraged complaints by Relator's members concerning the anesthesiologists' false and fraudulent billing practices; (5) denied CRNAs who had signed over their billing rights to the hospitals, access to Medicare denials for review and appeal; and (6) in the case of defendants Unity, Mercy, Abbott Northwestern and St. Cloud, retaliated against Relator's members for reporting such fraud. Defendant hospitals did not appropriately bill using a non-directed CRNA modifier when they knew the anesthesiologists were not participating in some procedures and not meeting minimal medical direction or personal performance requirements in others. Instead, they allowed – and expected MDAs to come to medical records and sign cases they were not involved in. This

practice resulted in Medicare paying almost twice as much.

71. Most notably, after CRNAs (members of Relator) at defendants Unity and Mercy Hospitals reported to those hospitals (including directly to defendant Murphy) and produced to them records documenting instances of fraudulent billing by anesthesiologist defendants, those hospitals, in concert with the anesthesiologists, fired the CRNAs and pressured them to become employed by the anesthesiologists.

72. Essentially the same scenario unfolded at defendant St. Cloud Hospital. In 1992, CRNA supervisors on behalf of the entire staff wrote and verbally complained about the fraudulent billing. Thereafter, they were first downgraded from medical associates to medical assistants and then fired and coerced to work for the defendant St. Cloud anesthesiologists.

73. The hospital defendants were motivated in the concerted action by (1) the desire to permit the anesthesiologists to continue their fraudulent billing practices; and (2) the desire of the hospitals to avoid confrontation with the anesthesiologists over – but simultaneously to distance themselves from – the anesthesiologists' fraud. The firing by the hospitals and rehiring by the anesthesiologists of the CRNAs was calculated to accomplish these purposes by giving the anesthesiologists sole control over billing for all anesthesia services – whether performed by the MDAs themselves, by CRNAs themselves, or by a combination of the two – thereby eliminating the risk that CRNAs would continue to expose the anesthesiologists' fraud by submitting to Medicare and others separate bills belying the fraudulent bills submitted by the anesthesiologists.

74. Relator is informed and believes that the global elimination of CRNAs as employees of the hospitals and use of economic coercion, including severance pay, to compel the CRNAs to be employed by defendant anesthesiologists was planned and coordinated by defendants. In addition, St. Cloud, Unity, Mercy and Abbott Northwestern hospitals coordinated the termination of CRNAs and exchanged information between themselves in order to facilitate this result for the benefit of MDAs. In order to conceal what defendant hospitals knew to be facilitation of defendant anesthesiologists' billing fraud, defendants engineered a pretext whereby defendants claimed that various of defendant hospitals were losing money on CRNAs when, in fact, those hospitals own records demonstrate that the CRNA employees were profitable. Defendant hospitals were also motivated by their desire to perpetuate an even wider fraud on the insurance companies and citizens of Minnesota which would actually increase the cost of anesthesia to patients and insurers rather than decrease it.

ENORMITY OF DEFENDANTS' FRAUD

75. It is estimated that between 1988 and the date of this Third Amended Complaint, defendant anesthesiologists collectively submitted in excess of 100,000 individual false claims for time-billed procedures to Medicare for services performed at their hospitals and received at least $13 million. Relators currently have information supporting the conclusion that by the end of 1994 defendants had submitted approximately 88,000 false claims. Relator is informed and believes these claims were false or fraudulent claims under Section 3729 because they did not satisfy one or more of the requirements for reimbursement.

Furthermore, MANA is informed the defendants' fraud is continuing and ongoing as of the date of this Third Amended Complaint.

76. Defendants are liable under 31 U.S.C. §§3729 and 3730 for (a) penalties in the maximum amount of Ten Thousand Dollars ($10,000.00) for each of these approximately 100,000 claims or One Billion Dollars ($1,000,000,000), plus (b) three times the amount of damages which the Government has sustained as a result of defendants' false claims which plaintiffs estimate to be approximately $39 million.

COUNT ONE

77. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 76 as if the same were set forth herein.

78. As more particularly set forth in the forgoing paragraphs, both defendant anesthesiologists and defendant hospitals have knowingly presented, or caused to be presented, to officers or employees of the United States Government, false or fraudulent claims for payment or approval in violation of 31 U.S.C. §3729(a)(1).

COUNT TWO

79. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 78 as if the same were set forth herein.

80. Defendant anesthesiologists and hospitals have knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims

paid or approved by the Government in violation of 31 U.S.C. §3729(a)(2).

COUNT THREE

81. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 80 as if the same were set forth herein.

82. Defendant hospitals and anesthesiologists and their defendant agents have conspired to defraud the Government by obtaining or seeking to obtain allowance and payment of false or fraudulent claims allowed or paid in violation of 31 U.S.C. §3729(a)(3).

COUNT FOUR

83. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 82 as if the same were set forth herein.

84. Defendant hospitals and anesthesiologists and their defendant agents have knowingly made, used, or caused to be made or used, false records of statements to conceal, avoid, or decrease obligations to pay or transmit money or property to the Government in violation of 31 U.S.C. §3729(a)(7).

COUNT FIVE

85. In addition to the misconduct described in the foregoing Counts, defendant hospitals have violated their obligations under their provider agreements with Medicare and have further conspired with defendant

anesthesiologists to submit false and/or fraudulent claims to the United States Government.

WHEREFORE, on behalf of the United States Government, Relator demands judgment against each of the above-named defendants, jointly and severally, as follows:

a. That by reason of the violations of the False Claims Act as set out in the First through Fourth Causes of Action, this Court enter judgment against Defendants in an amount up to Three (3) times the amount of damages the United States Government has sustained because of Defendants' actions, plus a civil penalty of not less than Five Thousand Dollars ($5,000.00) and not more than Ten Thousand Dollars ($10,000.00) for each separate claim which constitutes a violation of 31 U.S.C. §3729;

b. That Relator as *Qui Tam* Plaintiff be awarded the maximum amount allowed pursuant to Section 3730(d) of the False Claims Act and/or any other applicable provision of law;

c. That Relator be awarded all costs of this section, including attorneys' fees and court costs;

d. That Relator be awarded its expenses in connection with this action pursuant to 31 U.S.C. Section 3729.

e. That appropriate injunctive relief pursuant to 31 U.S.C. §3730(h) be awarded to Relator's members and others who have taken or may take lawful action in furtherance of this Complaint; and

f. That Plaintiff and the Relator receive such other and further relief as the Court may deem to be just and proper.

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Dated: March 20, 1997

TRIAL BY JURY

Plaintiffs hereby demand a trial by jury as to all issues.

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Dated: March 20, 1997

EXHIBIT "A"

The attached Exhibit is based upon partial information concerning the bills submitted to Medicare by the defendant anesthesiologists during the relevant time period. The numbers contained in the Third Amended Complaint are based upon Relator's estimation of the total number of bills actually submitted. The total number of false claims for which plaintiffs have documentation is approximately 88,000 as set forth herein. However, the schedule does not include fraudulent bills for medical direction submitted by the St. Cloud and Abbott Northwestern anesthesiologists and further does not include bills for medical direction from Unity, Mercy, North Memorial and Abbott Northwestern from 1994 to date.

Total Paid AA Cases	95% Total Paid AA Cases	Total Cases AA	95% Total Cases AA	Total Fraudulent Payments	Total Penalties
Summary for Provider = 059000456-Boeke, Gary (1574 detail records)					
$132,954.86	$128,310.27	613.00	487.35	$128,310.27	$4,873,500
Summary for Provider = 059000457 – Boyle, Phillip (1383 detail records)					
$158,739.35	$153,831.91	613.00	582.35	$153,631.91	$5,823,500
Summary for Provider = 059000458 – Espeland, Lee (1973 detail records)					
$31,584.98	$31,124.99	178.00	170.05	$31,124.99	$1,700,500
Summary for Provider = 059000459 – Espelien, Alan (1374 detail records)					
$79,963.38	$77,432.72	496.00	471.20	$77,432.72	$4,712,000
Summary for Provider = 059000460-Evenson, Curtis (525 detail records)					
$58,572.71	$57,933.89	220.00	209.00	$57,933.98	$2,090,000
Summary for Provider = 059000461 – Gacusana, Joseph (693 detail records)					
$35,816.73	$34,943.30	232.00	220.40	$34,943.30	$2,204,000
Summary for Provider = 059000462 – Halvorson, Paul (1835 detail records)					
$100,142.53	$97,153.66	438.00	416.10	$97,153.66	$4,161,000
Summary for Provider = 059000463 – Johnson, Craig (1429 detail records)					
$122,589.13	$118,419.89	486.00	461.70	$118,410.99	$4,617,000
Summary for Provider = 059000464 – Johnston, Dan (213 detail records)					
$23,446.50	$22,884.24	107.00	101.65	$22,884.24	$1,016,500

Summary for Provider = 059000465 – Lang, Lance (1041 detail records)					
$80,265.08	$76,840.11	364.00	345.80	$76,840.11	$3,458,000
Summary for Provider = 059000466 – McMillan, Alan (956 detail records)					
$71,117.84	$67,561.97	330.00	313.50	$67,561.97	$3,135,000
Summary for Provider = 059000467 – Rajala, Mary (282 detail records)					
$13,635.38	$12,953.62	81.00	74.85	$12,953.62	$769,500
Summary for Provider = 059000468 – Reitz, Alan (800 detail records)					
$56,632.51	$53,800.88	247.00	234.65	$53,800.88	$2,346,500
Summary for Provider = 059000469 – Rice, William (1648 detail records)					
$76,318.16	$73,762.10	486.00	442.70	$73,762.10	$4,427,000
Summary for Provider = 059000471 – Zwick, Annette (906 detail records)					
$73,251.13	$69,588.57	289.00	274.55	$69,588.57	$2,745,500
Summary for "FAC" = AASC (16459 detail records)					
$1,114,829.11	$1,076,342.34	5,061.00	4,807.95	$1,078,342.34	$48,079,500

Total Paid AA Cases	95% Total Paid AA Cases	Total Cases AA	95% Total Cases AA	Total Paid Medically Directed Cases	95% Total Paid Medically	Total Medically Directed Cases	95% Total Medically Directed Cases	Total Fraudulent Payments	Total # Fraudulent Cases	Total Penalties
Summary for Provider = 050000172 – Pizarro, Remi (725 detail records)										
$73,982.41	$23,758.84	112.00	106.40	$52,111.04	$51,774.46	614.00	583.30	$75,533.30	489.70	$6,897,000
Summary for Provider = 050000173 – Everly, Stephen (444 detail records)										
$21,571.17	$21,409.47	108.00	102.60	$26,599.52	$26,361.25	336.00	319.20	$47,770.71	421.80	$4,218,000
Summary for Provider = 050000174 – Meredith, John (587 detail records)										
$24,623.68	$24,403.06	120.00	114.00	$43,885.38	$43,534.16	477.00	453.15	$67,937.22	567.15	$5,671,500
Summary for Provider = 050000175 – Hoffman, J (689 detail records)										
$33,371.38	$33,147.91	132.00	125.40	$43,431.58	$42,994.72	557.00	529.15	$76,142.63	654.55	$6,545,500
Summary for Provider = 050000176 – Mazer, Thomas (581 detail records)										
$28,154.90	$27,916.75	113.00	107.35	$37,804.57	$37,602.06	478.00	454.10	$65,518.81	561.45	$5,614,500
Summary for Provider = 050000177 – Lader, Steven (778 detail records)										
$33,608.92	$33,397.68	137.00	130.16	$47,289.77	$48,777.92	641.00	608.95	$80,175.80	739.10	$7,491,000
Summary for Provider = 050000178 – Petersen, Michael (743 detail records)										
$29,626.92	$29,331.49	147.00	139.65	$45,863.14	$45,509.20	598.00	566.20	$74,840.68	705.85	$7,058,500
Summary for Provider = 050000179 – Almore, William (710 detail records)										
$32,723.12	$32,461.54	149.00	141.56	$45,416.91	$45,091.99	561.00	532.95	$77,553.53	674.50	$6,745,000
Summary for Provider = 050000180 – Schultz, David (779 detail records)										
$31,023.96	$30,706.50	121.00	114.95	$42,255.14	$41,868.72	658.00	625.10	$72,595.30	740.05	$7,400,500
Summary for Provider = 050000181 – Montgomery, Michael (681 detail records)										
$33,462.05	$33,204.53	128.00	121.60	$41,386.05	$40,946.70	553.00	525.35	$74,151.23	646.95	$6,469,500
Summary for Provider = 050000274 – Benthall, Carolyn (25 detail records)										
$340.16	$334.56	3.00	2.85	$2,304.64	$2,258.89	22.00	20.90	$2,593.45	23.75	$237,500

Summary for Provider = 050000299 – Monehart, Daniel (803 detail records)										
$26,104.56	$25,934.87	104.00	98.80	$52,418.27	$51,953.97	699.00	684.05	$77,888.64	762.85	$7,628,500
Summary for Provider = 050000068 – Walker, Brian (626 detail records)										
$23,167.19	$23,006.33	107.00	101.85	$37,065.91	$36,609.60	519.00	491.05	$59,475.93	594.70	$5,947,000
Summary for Provider = 050000368 – Wright, Thomas (605 detail records)										
$23,082.62	$22,976.72	103.00	97.85	$36,313.40	$36,013.55	503.00	477.85	$58,990.26	575.70	$5,757,000
Summary for Provider = 060000434 – Larson, Loren (282 detail records)										
$3,748.46	$3,714.27	33.00	31.35	$18,587.87	$18,400.91	249.00	236.55	$22,115.18	267.9	$2,679,000
Summary for Provider = 060000550 – Schoenecker, Joan (117 detail records)										
$11,346.40	$11,278.68	58.00	53.20	$2,775.10	$2,754.54	61.00	57.95	$14,033.22	111.15	$1,111,500
Summary for Provider = 050000633 – Adkins-Finke, Bonnie (25 detail records)										
$2,839.42	$2,916.38	25.00	23.75	$0.00	$0.00	0.00	0.00	$2,916.38	23.75	$237,500
Summary for Provider = 050000654 – Hendricks, John (9 detail records)										
$1,847.34	$1,802.81	8.00	8.55	$0.00	$0.00	0.00	0.00	$1,802.91	8.55	$85,500
Summary for Provider = 061610845 – Anesthesiology, PA (201 detail records)										
$51,292.98	$50,909.76	201.00	190.95	$0.00	$0.00	0.00	0.00	$50,999.78	190.95	$1,908,500
Summary for Provider = 060000470 – Smith, Weston (1 detail record)										
$0.00	$0.00	0.00	0.00	$227.36	$215.99	1.00	0.95	$215.99	0.95	$9,500
Summary for "FAC" = Metro Anesthesia Network (9431 detail records)										
$1,358,646.97	$1,508,848.50	6,967.00	6,618.63	$1,417,339.97	$1,380,875.50	18,923.00	17,976.85	$2,889,674.00	24,525.50	$245,955,000

Total Paid AA Cases	95% Total Paid AA Cases	Total Cases AA	95% Total Cases AA	Total Paid Medically Directed Cases	95% Total Paid Medically	Total Medically Directed Cases	95% Total Medically Directed Cases	Total Fraudulent Payments	Total # Fraudulent Cases	Total Penalties
Summary for Provider = 050000071 – Metro Anesthesia Network (8706 detail records)										
$326,895.03	$321,830.29	1,661.00	1,577.95	$426,236.80	$416,736.22	5,046.00	4,793.70	$738,566.51	6,371.65	$63,716,500
Summary for Provider = 050000072 – Abbey, Thelma (393 detail records)										
$15,133.79	$14133.79	90.00	85.50	$26,337.07	$25,873.65	303.00	287.85	$40,480.58	373.35	$3,733,500
Summary for Provider = 050000073 – Baggenstoss, Gary (567 detail records)										
$32,876.84	$32,072.51	123.00	116.85	$31,848.02	$31,332.93	434.00	412.30	$63,405.44	529.15	$5,291,500
Summary for Provider = 050000074 – Castillejos, Minda (300 detail records)										
$9,607.68	$9,213.96	68.00	64.60	$18,886.80	$18,525.96	232.00	220.40	$27,738.93	285.00	$2,860,000
Summary for Provider = 050000075 – Cumming, James (730 detail records)										
$27,441.41	$26,909.02	151.00	143.45	$41,847.98	$41,116.35	579.00	550.05	$68,025.37	693.50	$8,935,000
Summary for Provider = 050000077 – Hong, Sang (620 detail records)										
$13,092.78	$12,663.57	95.00	90.25	$39,417.71	$38,799.49	525.00	496.75	$51,463.07	598.00	$5,890,000
Summary for Provider = 050000079 – Kloepper II, Raymond (691 detail records)										
$26,597.44	$25,798.78	155.00	147.25	$39,232.33	$38,543.05	536.00	509.20	$64,341.83	656.45	$6,584,500
Summary for Provider = 050000080 – Magdsick, John (531 detail records)										
$23,313.47	$22,537.81	112.00	106.40	$34,093.54	$34,051.99	419.00	396.05	$56,589.81	504.45	$5,044,500
Summary for Provider = 050000081 – Maggs, Thomas (480 detail records)										
$31,697.53	$30,485.92	142.00	134.90	$28,689.19	$28,120.85	338.00	321.10	$58,806.77	456.00	$4,560,000
Summary for Provider = 050000082 – Roseberg, John (546 detail records)										
$48,630.57	$47,124.74	180.00	171.00	$28,003.65	$27,507.97	368.00	347.70	$74,632.71	516.70	$5,187,000
Summary for Provider = 050000083 – Rydberg, John (351 detail records)										
$14,378.82	$13,865.89	104.00	98.80	$22,477.10	$22,130.78	247.00	234.65	$35,996.48	333.45	$3,334,500

Summary for Provider = 050000084 – Sperry, Mark (435 detail records)										
$22,389.03	$21,618.18	106.00	100.70	$27,173.98	$26,858.37	329.00	312.55	$48,273.53	413.25	$4,132,500
Summary for Provider = 060000085 – Suh, Jei (781 detail records)										
$31,248.85	$30,383.30	168.00	180.56	$44,827.64	$43,923.08	612.00	581.40	$74,306.38	741.95	$7,419,500
Summary for Provider = 050000324 – Potts, Thomas (518 detail records)										
$23,432.89	$22,658.67	113.00	107.35	$31,069.37	$30,484.36	406.00	385.70	$53,343.03	493.05	$4,930,500
Summary for Provider = 050000344 – Janossy, Theodore (393 detail records)										
$23,471.43	$22,783.61	106.00	100.70	$24,548.14	$24,164.13	287.00	272.65	$46,947.74	373.35	$3,733,500
Summary for Provider = 050000371 – Yue, Jeffrey (449 detail records)										
$24,556.08	$23,810.40	123.00	116.85	$22,939.05	$22,470.34	326.00	309.70	$46,280.74	426.55	$4,265,500
Summary for Provider = 050000386 – Heil, Teri (321 detail records)										
$18,107.92	$17,575.11	102.00	96.90	$15,455.32	$15,091.27	219.00	208.05	$32,666.38	304.95	$3,049,500
Summary for Provider = 050000605 – Eggen, Mark (37 detail records)										
$8,914.96	$8,469.21	37.00	35.15	$0.00	$0.00	0.00	0.00	$8,489.21	35.15	$351,500
Summary for "FAC" = MAPA (14839 detail records)										
$2,272,283.21	$2,213,494.42	10,603.00	10,072.85	$2,320,929.04	$2,264,278.69	30,126.00	28,619.70	$4,479,773.12	38,692.55	$386,925,500

Total Paid AA Cases	95% Total Paid AA Cases	Total Cases AA	95% Total Cases AA	Total Fraudulent Payments	Total Penalties
Summary for Provider = 050000100 – Tiu, Otello (1087 detail records)					
$83,729.11	$82,343.87	268.00	254.60	$82,343.87	$2,546,000
Summary for Provider = 050000101 – Stauffer, William (498 detail records)					
$6,409.11	$6,197.07	60.00	57.00	$6,197.07	$570,000
Summary for Provider = 050000102 – Peterson, John (1368 detail records)					
$52,893.92	$52,739.62	165.00	156.75	$52,739.62	$1,567,500
Summary for Provider = 050000103 – Giron, Luis (1212 detail records)					
$150,698.72	$147,644.73	481.00	456.95	$147,644.73	$4,569,500
Summary for Provider = 050000104 – Pereira, Xavier (972 detail records)					
$92,664.25	$90,846.24	324.00	307.80	$90,846.24	$3,078,000
Summary for Provider = 050000105 – Skoog, Richard (1243 detail records)					
$147,740.68	$144,938.21	415.00	394.25	$144,938.21	$3,942,500
Summary for Provider = 050000106 – Menzel, M (1026 detail records)					
$97,389.48	$95,945.35	290.00	275.50	$95,945.35	$2,755,000
Summary for Provider = 050000107 – Beverlin, Bryce (190 detail records)					
$175,765.81	$172,364.48	503.00	477.85	$172,364.48	$4,778,500
Summary for Provider = 050000108 – Dwarkeneth, Rajarso (1351 detail records)					
$156,385.12	$163,541.68	441.00	418.95	$153,541.68	$4,189,500
Summary for Provider = 050000109 – Shaw, Jeffrey (1171 detail records)					
$133,556.01	$131,081.90	461.00	437.95	$131,081.90	$4,379,500
Summary for Provider = 050000110 – Trennier, Robert (1129 detail records)					
$104,175.99	$102,335.49	312.00	296.40	$102,335.48	$2,984,000

Summary for Provider = 050000111 – Nissen, Mark (1608 detail records)					
$208,341.93	$204,406.30	585.00	665.25	$204,408.30	$5,652,500
Summary for Provider = 050000112 – Gudman, John (755 detail records)					
$49,269.35	$48,137.75	272.00	258.40	$48,137.75	$2,584,000
Summary for Provider = 050000113 – Munich, James (1128 detail records)					
$124,667.88	$122,547.68	401.00	380.95	$122,547.68	$3,809,500
Summary for Provider = 050000114 – Gayes, James (1485 detail records)					
$233,645.80	$228,154.49	747.00	709.85	$228,154.49	$7,096,500
Summary for Provider = 050000115 – Johnson, Richard (1090 detail records)					
$106,902.63	$107,058.12	352.00	334.40	$107,056.12	$3,344,000
Summary for Provider = 050000116 – Boening, Joan (988 detail records)					
$47,597.23	$46,568.23	240.00	228.00	$46,568.23	$2,280,000
Summary for Provider = 050000117 – Groves, Nancy (771 detail records)					
$18,632.45	$18,431.00	105.00	99.75	$18,431.00	$997,500
Summary for Provider = 050000118 – Wintermute, John (1275 detail records)					
$153,502.54	$150,312.62	408:00	387.60	$150,312.62	$3,496,000
Summary for Provider = 050000119 – Meisner, Judith (1062 detail records)					
$114,865.58	$113,050.00	368.00	349.60	$113,050.00	$3,496,000
Summary for Provider = 050000120 – Burke, Mitchell (1070 detail records)					
$177,773.10	$172,822.38	564.00	535.80	$172,822.38	$5,358,000
Summary for Provider = 050000387 – Plul, David (772 detail records)					
$108,306.46	$104,958.90	337.00	320.15	$104,958.05	$3,201,500
Summary for Provider = 050000388 – McKlveen, Robert (657 detail records)					
$103,806.16	$100,858.90	321.00	304.95	$100,856.90	$3,049,500

Summary for Provider = 050000457 – Lillehei, John (496 detail records)					
$71,005.65	$68,400.72	264.00	250.80	$88,400.72	$2,508,000
Summary for Provider = 050000467 – Blomberg, Richard (440 detail records)					
$88,675.82	$85,452.12	273.00	258.35	$85,462.12	$2,593,500
Summary for Provider = 050000478 – Engwell, Richard (248 detail records)					
$4,908.24	$4,887.92	43.00	40.85	$4,687.92	$408,500
Summary for Provider = 053810046 – Northwest Anesthesia, PA (6120 detail records)					
$572,431.28	$509,247.90	1,853.00	1,760.35	$589,247.98	$17,603,500
Summary for "FAC" = NIFA (32410 detail records)					
$5,459,396.96	$5,537,991.55	21,464.00	20,390.80	$5,537,991.51	$203,908,000

In The United States District Court
District of Minnesota

MANA, et al. vs. Unity Hospital, et al.

Deposition of Patrict Donohue-1/8/98

Donohue, Patrick V01 01/08/98

* * *

[27] A It's a bulletin that we issued to anesthesia providers in 1989.

Q I believe this was the earliest of the provider bulletins that you produced in connection with response to the subpoena, is that correct, earliest in time?

A It could be, yes.

Q Could you direct your attention to the second page of the exhibit, I guess it's page 3 of the document?

A (Examining document.)

Q Was the document responsive to the subpoena because of the material at the top of the page 3 beginning when an anesthesiologist and an anesthetist are both involved in a single procedure?

MR. STONE: Object to the form of the question.

A The document was produced because it was considered to be communications that we had with providers about anesthesia and that was one of the things called for in the subpoena.

Q Okay. Then could you identify Exhibit 1027 for me which also came from your files?

A It's a Medicare newsletter that was issued in August of 1991.

Q And I have a few questions about the bottom part of the second page, Anesthesiologist and CRNA – Single Service. [28] Could you take a moment to review that paragraph?

A (Examining document.)

Q Let me know when you're ready.

A All right.

Q Can you tell me what the background is to the publication of this paragraph, how this set of CPT codes came about?

A We had been advised by anesthetist providers as I recall that Blue Shield had come up with a list of procedure codes that they would assume medical necessity for both the anesthetist and the anesthesiologist's involvement in the request was that we would agree to the same list and we did and then published it.

Q So these are procedure codes on which Travelers considered and would reimburse for medically necessary CRNA services in addition to the anesthesiologist's service?

A That's correct.

Q And that would be on cases where there was no concurrent case? Correct?

A That's also correct.

Q All right. Did Travelers ever issue any instructions to providers as to – let me start over. Am I correct that there are two modifiers under which CRNAs could bill, one for medically directed services and one for [29] nonmedically directed services?

A That's correct.

Q Did Travelers ever issue any instruction as to which modifier CRNAs were to use in billing for these medical necessity cases?

A No.

Q Was it your understanding that the services would be billed using the medically directed modifier?

A That's correct.

Q And am I also correct that Travelers would reimburse at two different rates for CRNA services, a medically directed rate and a nonmedically directed rate?

A That's correct.

Q And what reimbursement rate were CRNA services on medical necessity cases reimbursed?

A I don't recall what it was at that time.

Q Has it changed over time?

A Yes.

Q So at one time it was the nonmedically directed and at one time it was the medically directed rate?

A I'm sorry. I misunderstood the original question I think.

Q Okay. Let's go back. Medicare reimburses for CRNA services at one of two rates, medically directed or nonmedically directed? Is that correct?

* * *

[145] A. Yes.

Q What was that?

A An 11 county area that encompassed the south-eastern corner of the state, Twin City and Rochester areas.

Q When did your territory expand?

A March 1st of 1996.

Q It went from the 11 county area to the entire state?

A Correct.

Q You in effect took over the carrier duties that Blue Cross/Blue Shield had been performing?

A For the Part B side of Medicare, yes.

Q How many anesthesia providers were there in the 11 county territory that you had?

A I don't know.

Q Do you have any estimate?

A I really have no idea.

Q Do you have any idea how many anesthesia providers are in the State of Minnesota?

A No.

Q Despite the appearance of this deposition, your job encompasses more than dealing with anesthesia billing? Right?

A Most of the time, yes.

Q Can you rank for us the relative complexity of Medicare billing regulations for anesthesia compared to Medicare [146] regulations for billing in other medical specialties?

MR. STONE: Object to the form of the question.

A Anesthesia would be at the top.

Q Why is that?

A It's more complex than the other areas.

Q And why is it more complex than the other areas?

A Because the whole pricing and allowable charge concepts are different than for other medical services.

Q Can you give us a general summary of why they're different? What are the other medical services' charge based on?

A For example, another physician service, say a visit or a physical examination is identified to us by a procedure code and we have an allowance in our system for that procedure code. It's as simple as that. With regard to anesthesia, there is a basic value for every anesthesia procedure but with regard to the specific procedure there's a time element that is also reflected in the allowance and the charge and then the distinction between a personally performed service and a medically directed service both for the anesthesiologist and for the anesthetist.

Q Do any of the other medical services have concepts such as personal performance versus medically directed?

* * *

[SEAL]

FOR IMMEDIATE RELEASE

CIV

THURSDAY, FEBRUARY 24, 2000

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JUSTICE DEPARTMENT RECOVERS OVER $3 BILLION IN WHISTLEBLOWERS FALSE CLAIMS ACT AWARDS AND SETTLEMENTS

WASHINGTON, D.C. – More than $3 billion has been recovered in civil fraud cases brought under the whistleblower provisions of the False Claims Act, since the law was amended in 1986, the Justice Department announced today. Almost half of the recoveries have come in the last two and a half years. "It took us 12 years – to the end of fiscal year 1998 – to recover $2 billion in civil fraud cases brought under the whistleblower provisions," said Acting Assistant Attorney General David W. Ogden for the Civil Division. "We have reached the $3 billion mark just 16 months later." Ogden stressed that besides providing monetary recovery, the whistleblower suits have also had a deterrent effect among recipients of federal funds. The False Claims statute allows private persons, known as "relators," to file suit on behalf of the United States alleging that false or fraudulent claims have been submitted to the government. Persons who file *qui tam* suits may recover from 15 to 25 percent of the settlement or judgment if the federal government intervenes in the case, or

up to 30 percent if they pursue it on their own. More than 3000 such suits have been filed since 1986. The number of *qui tam* suits filed has risen from 33 per year in the year after 1986 to 483 in the last fiscal year. The whistleblower provisions have yielded recoveries of more than $3.5 billion to date: $3.3 billion in cases that the Department of Justice pursued and $211 million in cases litigated by whistleblowers after the Department of Justice declined to pursue the case. The Department of Justice has paid whistleblowers more than $550 million as their statutory shares, with additional awards pending. "The False Claims Act's *qui tam* provisions have provided a remarkable return for the taxpayers of this country," said Ogden. "The Department of Justice's recovery of more than $3.3 billion through whistleblower suits demonstrates that the public-private partnership encouraged by the statute works and is an effective tool in our continuing fight against the fraudulent use of public funds." Among the most recent recoveries are:

- National Medical Care, now also known as Fresenius Medical Care, North America, the largest provider of dialysis services in the United States, agreed to pay $375 million to resolve *qui tam* allegations that the company submitted false claims for laboratory tests and conspired to pay illegal kickbacks. This is the largest civil recovery in a health care fraud case.

- Beverly Enterprises Inc., the nation's largest operator of nursing homes, agreed to pay $170 million to settle allegations that it defrauded Medicare by fabricating records to make it appear that nurses were devoting

much more time to Medicare patients than they actually were.

- Olsten Corporation paid $40.9 million to settle allegations that Olsten and Columbia/HCA had disguised unallowable acquisition costs as allowable management fees when Columbia/HCA acquired home health agencies in several states. Olsten and its subsidiaries had provided management and staffing services for the home health agencies.

While almost half of the *qui tam* filings, and more than half of the *qui tam* recoveries, involve health care fraud, whistleblower suits have alleged fraud against a wide range of federal government agencies. For example:

- Chevron Corporation agreed to pay the U.S. $86.2 million to resolve whistleblower claims under the False Claims Act that the corporation and affiliated companies underpaid royalties due for oil produced on federal and Indian leases since 1988.

- Mobil Oil Corporation agreed to pay the U.S. $45 million, and Oxy-USA, Inc. paid $7.3 million, to resolve similar claims of underpayment of royalties.

Ogden praised the work of Senator Charles Grassley of Iowa and Representative Howard L. Berman of California, who sponsored the 1986 amendments that made it easier for such cases to be filed. He also stressed that the recoveries could not have been achieved without the outstanding and tireless efforts of the attorneys in the Civil Division and the United States Attorneys' offices

throughout the country working in cooperation with agency investigators.

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00-079

U.S. Department of Justice
Office of the Deputy Attorney General

The Deputy Attorney General *Washington, DC 20530*

June 3, 1998

MEMORANDUM FOR: All United States Attorneys
All First Assistant United States Attorneys
All Civil Health Care Fraud Coordinators in the Offices of United States Attorneys
All Trial Attorneys in the Civil Division Commercial Litigation Section

FROM: Eric H. Holder, Jr.
Deputy Attorney General

SUBJECT: Guidance on the Use of the False Claims Act in Civil Health Care Matters

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One of the Department's most important tools in protecting the integrity of Medicare and other taxpayer-funded health care programs is the civil False Claims Act. While the broad reach and substantial damages and civil penalties under the Act make it one of the Department's most powerful tools, Departmental attorneys are obligated to use their authority under the Act in a fair and responsible manner. This is particularly important in the context of national initiatives, which can have a broad impact on health care providers across the country.

This guidance is being issued to emphasize the importance of pursuing civil False Claims Act cases against health care providers in a fair and even-handed manner, and to implement new procedures with respect to the development and implementation of national initiatives.

1. National Initiatives.

Generally, national initiatives deal with a common wrongful action accomplished in a like manner by multiple, similarly situated health care providers. National initiatives must be handled in a manner (i) that promotes consistent adherence to the Department's policies on enforcement of the False Claims Act, as well as a consistent approach to overarching legal and factual issues, (ii) while avoiding any rigid approach that fails to recognize the particular facts and circumstances of an individual case.

To achieve these objectives, the Department has instituted the following procedures:

(A) Legal and Factual Predicates.

Before alleging violations of the False Claims Act, whether in connection with a national initiative or otherwise, Department attorneys must evaluate whether the provider: (i) submitted false claims to the government, and (ii) submitted false claims (or any false statements made to get the false claims paid) with "knowledge" of their falsity, as defined in the Act. These are separate inquiries. Department attorneys shall not allege a violation of the False Claims Act unless both of these inquiries lead to the conclusion that there is a sufficient legal and factual

predicate for proceeding. The following issues, among other issues, shall be considered in these determinations:

(i) Do False Claims Exist?

a. *Examine Relevant Statutory and Regulatory Provisions and Interpretive Guidance.* Department attorneys shall examine relevant statutory and regulatory provisions, as well as any applicable guidance from the program agency or its agents, to determine whether the claims are false. In certain circumstances, such as when a rule is technical or complex, Department attorneys should communicate with knowledgeable personnel within the program agency (*e.g.*, the Health Care Financing Administration, TRICARE, Office of Personnel Management) concerning the meaning of the provision.

b. *Verify the Data and Other Evidence.* Department attorneys shall take appropriate steps to verify the accuracy of data upon which they are relying, either independently, or with the assistance of the fiscal intermediaries and carriers, the Department of Health and Human Services – Office of Inspector General, the Federal Bureau of Investigation, or another investigative agency.

c. *Conduct the Necessary Investigative Steps.* Department attorneys should conduct such investigative steps as are necessary under the circumstances, including where appropriate, the subpoenaing of documents and the interviewing of witnesses.

(ii) Did the Provider Knowingly Submit the False Claims?

In the event the claims are false, Department attorneys must next evaluate whether the health care provider "knowingly" submitted the false claims or "knowingly" made false statements to get the false claims paid. As set forth above, and before making this determination, Department attorneys should conduct such investigative steps as necessary under the circumstances, including where appropriate the subpoenaing of documents and the interviewing of witnesses. Under the False Claims Act, false claims and false statements are submitted "knowingly" if the provider had actual knowledge of their falsity, or acted with deliberate ignorance or reckless disregard as to their truth or falsity. While relevant factors will vary from case to case and the list below is not intended to be exhaustive, factors that must be considered are:

a. *Notice to the Provider*. Was the provider on actual or constructive notice, as appropriate, of the rule or policy upon which a potential case would be based?

b. The Clarity of the Rule or Policy. Under the circumstances, is it reasonable to conclude that the provider understood the rule or policy?

c. *The Pervasiveness and Magnitude of the False Claims*. Is the pervasiveness or magnitude of the false claims sufficient to support an inference that they resulted from deliberate ignorance or intentional or reckless conduct rather than mere mistakes?

d. *Compliance Plans and Other Steps to Comply with Billing Rules*. Does the health care

provider have a compliance plan in place? Is the provider adhering to the compliance plan? What relationship exists between the compliance plan and the conduct at issue? What other steps, if any, has the provider taken to comply with billing rules in general, or the billing rule at issue in particular?

e. *Past Remedial Efforts*. Has the provider previously on its own identified the wrongful conduct currently under examination and taken steps to remedy the problem? Did the provider report the wrongful conduct to a government agency?

f. *Guidance by the Program Agency or its Agents*. Did the provider directly contact either the program agency (*e.g.*, the Health Care Financing Administration) or its agents regarding the billing rule at issue? If so, was the provider forthcoming and accurate and did the provider disclose all material facts regarding the billing issue for which the provider sought guidance? Did the program agency or its agents, with disclosure of all relevant, material facts, provide clear guidance? Did the provider reasonably rely on such guidance in submitting the false claims?

g. *Have There Been Prior Audits or other Notice to the Provider of the Same or Similar Billing Practices*?

h. *Any Other Information That Bears on the Provider's State of Mind in Submitting the False Claims*.

(B) Oversight by National Initiative Working Groups.

For all current and future national initiatives, the Attorney General's Advisory Committee (AGAC) and the Civil Division shall establish a working group to coordinate the development and implementation of each initiative.

Working groups will be comprised of Assistant United States Attorneys and Civil Division attorneys with particular expertise in health care fraud. In accordance with the health care guidelines promulgated in January 1997, in appropriate instances each working group may also need to coordinate and plan the initiative with the Department's Criminal Division.

Each working group will (i) examine the initiative to ensure that a factual and legal predicate is present for the initiative prior to its implementation, (ii) prepare initiative-specific guidance and sample documents (such as legal analyses, summaries of audit data, contact letters, tolling agreements, compliance and settlement agreement language) for use in the initiative, and (iii) prepare a general investigative plan, setting forth suggested investigative steps that each office should undertake prior to proceeding. Working groups shall be responsible for coordination with law enforcement agencies, the Health Care Financing Administration, and other appropriate entities.

While the working groups shall be responsible for coordinating the overall development and implementation of national initiatives, each matter against a specific provider must be evaluated on a case-by-case basis.

(C) Use of Contact Letters in National Initiatives.

As outlined above, Department attorneys participating in national initiatives shall, in general, make initial contacts with health care providers, to resolve a case, through the use of "contact" letters. The purpose of a contact letter is to notify a provider of their potential exposure under the False Claims Act and to offer the provider an opportunity to discuss the matter *before* a specific demand for payment is made. In limited circumstances, where the specific facts of a situation warrant a different approach, Department attorneys may make an initial contact through other legitimate means.

The use of contact letters to make initial contact with health care providers is in furtherance of Executive Order 12988, which obligates Department attorneys to make a reasonable effort to notify the opposing party about the nature of the allegations, and attempt to resolve the dispute without litigation if at all possible. The type of contact employed will depend on the nature of the allegations and the stage of the investigation. Regardless of the form of initial contact, Department attorneys must ensure that health care providers are afforded: (i) an adequate opportunity to discuss the matter before a demand for settlement is made, and (ii) an adequate time to respond. In addition, Department attorneys shall grant all reasonable requests for extensions of time to the extent that they do not jeopardize the government's claims. The use of statutory tolling agreements are strongly encouraged to allow providers time to respond without jeopardizing the government's claims.

2. Alternative Remedies.

After reviewing the legal and factual circumstances of a particular matter, Department attorneys shall consider other available remedies – including administrative remedies such as recoupment of overpayments, program exclusions, and civil monetary penalties – to determine what remedy, or combination of remedies, would be the most suitable under the circumstances. Should the recoupment of an overpayment be the most appropriate remedy, Department attorneys shall consider referring the matter to the appropriate carrier/fiscal intermediary for appropriate action.

3. Ability to Pay Issues.

Attorneys shall consider any financial constraints identified by a provider in determining a fair, reasonable and feasible settlement between the parties. Hospitals and other health care providers citing an inability to pay a specific settlement amount should be asked to present documentation in support of their stated financial condition.

4. Rural and Community Health Care Provider Concerns – Impact on Availability of Medical Services.

When dealing with rural and community hospitals and other health care providers, Department attorneys shall consider the impact an action may have on the community being served. In determining an appropriate resolution, or deciding whether to bring an action, care must be taken to consider the community's interest in

access to adequate health care along with any other relevant concerns.

5. Hospitals and Other Health Care Providers Not Represented by Counsel.

Department attorneys shall pay special attention to contacts with hospitals and other providers that choose (due to financial constraints or otherwise) to resolve claims without legal representation. Department attorneys faced with this circumstance must carefully assess every action taken to avoid even an appearance of coercion or overreaching because of the absence of opposing counsel.

6. Minimizing Burdens Imposed on Providers During Investigations.

Department attorneys also should be mindful of the ways in which our investigations and audits can disrupt and burden the day-to-day operations of providers in both a financial and practical sense. In developing and implementing an investigative plan, we should do what we can do to minimize these adverse effects, while still meeting our obligation to diligently investigate allegations of potential fraud. For example, while recognizing that certain circumstances might warrant different approaches, Department attorneys should consider a provider's request to accept the results of an audit of a sample of claims in lieu of a complete audit.

7. Provider Assistance with the Investigation.

In determining an appropriate settlement amount, Department attorneys should consider the extent to which a health care provider has cooperated with the audit or investigation of the relevant matter.

8. Individualized Review.

The proper determination as to the use and application of the False Claims Act or other appropriate remedy requires an individualized review of each case, ensuring that each of the above factors are given full consideration

9. Review of Guidance.

In order to assure the fair and appropriate application of the False Claims Act, this guidance will be subject to review in six months.

10. Additional Information.

Questions regarding use of the False Claims Act should be referred to the Health Care Fraud Coordinator in your district, or to Robert Liles, Health Care Fraud Coordinator for the Executive Office for United States Attorneys (tel. no. 202-616-5136), or Shelley R. Slade, Health Care Fraud Coordinator for the Civil Division (tel. no. 202-307-0264).

N 0208

[SEAL]

STATE OF MINNESOTA

Department of State

In All To Whom These Presents Shall Come, Greeting:

Whereas, Articles of Incorporation, duly signed and acknowledged under oath, have been recorded in the office of the Secretary of State, on the **-7th-** day of **April**, A. D. 19**75** for the incorporation of **Minnesota Association of Nurse Anesthetists** under and in accordance with the provisions of the Minnesota Nonprofit Corporation Act, Minnesota Statutes, Chapter 317,

Now, Therefore, I, Joan Anderson Growe, Secretary of State of the State of Minnesota, by virtue of the powers and duties vested in me by law, do hereby certify that the said **Minnesota Association of Nurse Anesthetists** is a legally organized Corporation under the laws of this State.

Witness my official signature hereunto subscribed and the Great Seal of the State of Minnesota hereunto affixed this **-seventh-** day of **-April-** in the year of our Lord one thousand nine hundred and **seventy-five**

/s/ Joan Anderson Growe
Secretary of State.

ARTICLES OF INCORPORATION
OF
MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS

We, the undersigned, being citizens of the United States, and all for the purpose of forming a charitable and benevolent corporation pursuant to the Minnesota Non-profit Corporation Act, Chapter 317 of the Minnesota Statutes, do hereby certify:

ARTICLE I

Name

The name of this corporation shall be MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS.

ARTICLE II

Purpose

It shall be the objects of this Association to promote the best interests of its members, cooperate with the American Association of Nurse Anesthetists, facilitate cooperation between nurse anesthetists and the medical profession, hospitals and other agencies interested in anesthesia, act as collective bargaining agent for its members, and in general to advance the science and art of anesthesia.

ARTICLE III

Authority and Restrictions

This corporation shall have the authority, in addition to but not by way of limitation of any authority conferred upon it by law:

A. To acquire by way of gift, devise, bequest, purchase or otherwise, or to lease or construct or cause to be constructed, facilities for maintaining and carrying out the work and activities of this corporation, either alone or in conjunction with others and on premises owned or leased by this corporation or on premises owned or leased by others; to acquire by gift, devise, purchase, or otherwise, and to own, hold, improve, lease, mortgage, pledge, sell, assign, transfer, convey, manage or otherwise deal in and with, the exercise of all rights of ownership in or in respect of every kind of real estate, improved or unimproved, and to procure buildings, structures or other improvements on any such real estate as may be necessary or convenient for carrying out any lawful purpose of this corporation.

B. To acquire, by way of gift, devise, bequest, purchase, or otherwise, and to hold, sell, assign, transfer, mortgage, pledge, or otherwise dispose of personal property of every kind, including shares, stocks, bonds, debentures, securities, and other obligations or evidence of indebtedness of any other corporation or foundation, either profit or nonprofit, public or private, domestic or foreign, as investments or otherwise, where it is necessary or proper for, or in connection

with any lawful purpose of this corporation and, while the owner thereof, to exercise all rights, powers and privileges of ownership, including the power to vote thereon.

C. To take, receive, and hold any real or personal property that is given, conveyed, bequeathed or devised to, or otherwise vested in the corporation, including the income there from, or both, and any income from or interest on any other money, property or fund that is given or bequeathed to the corporation, in trust for any purpose, subject to any use or condition, or upon any special or executory limitation that is consistent with the purposes of this corporation as set forth in these Articles.

D. To prepare for publication, publish or cause to be published, produce, manufacture, distribute, disseminate, exhibit, show or furnish for exhibition or showing, sponsor, or otherwise promote or develop, directly or indirectly, such books, pictures, magazines, papers, pamphlets, and other printed matter and such lectures, performances, exhibitions, motion pictures, radio programs, television programs, and the like as may be necessary, suitable, or convenient for carrying out the lawful purpose of this corporation.

E. To borrow money and incur indebtedness for any lawful purpose of this corporation from time to time without limit as to amount, and in connection therewith, to draw, make, accept, endorse, execute and issue notes, drafts, bills of exchange, bonds, debentures, and other negotiable or non-negotiable

instruments or evidences of indebtedness of any nature, and to secure payment thereof, and any interest thereon, by mortgage, pledge, deed of trust, assignment, or otherwise on or of any part or all of the assets of this corporation, including assets thereafter to be acquired.

F. To do all other acts and things and carry on and conduct all other activities necessary, suitable, convenient, useful, or expedient in connection with, or incidental to the accomplishment of, any of the purposes set forth in Article II of these Articles to the full extent permitted by the laws of the State of Minnesota.

G. To pursue its purposes and conduct and carry on any and all lawful business or activities in connection therewith or incidental thereto, or any part thereof, in the State of Minnesota, in any other state, territory, or possession of the United States, in the District of Columbia, and in any foreign country or countries, except that if any donor or contributor shall so specify, his or its gift or contribution shall be used by the corporation only within the United States or its possessions, or within any other territorial limits specified by that donor or contributor.

Notwithstanding any other provision of these Articles of Incorporation the corporation shall at all times be subject to the following restrictions:

A. The corporation shall neither have nor exercise any powers nor shall it engage directly or indirectly in any activity, that would invalidate its status as a corporation which is

exempt from Federal income taxation as an organization described in section 501(c)(6) of the Internal Revenue Code of 1954.

B. No substantial part of the activities of this corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation; nor shall it be in any manner or to any extent participate in, or intervene in any political campaign on behalf of any candidate for office; nor shall the corporation engage in any activities that are unlawful under applicable Federal, State, or local laws.

C. This corporation shall not operate for the primary purpose of carrying on a trade or business or any other activity for profit.

ARTICLE IV

No Pecuniary Gain to Members

No part of the net earnings of the corporation shall inure to the benefit of or be distributable to its members, directors, officers, or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Article II hereof.

ARTICLE V

No Personal Liability

The members, officers and directors of this corporation shall have no personal liability for corporate obligations.

ARTICLE VI

Registered Office

The location and Post Office address of the registered office of this corporation in the State of Minnesota shall be 319 – 15th Avenue S.E., c/o State Organization Services, Minneapolis, Minnesota, 55414.

ARTICLE VII

Directors

The corporation shall be operated by a Board of Directors the number of which is to be no more than twelve (12) and no less than three (3). The directors of the corporation are to be elected in accordance with the By-Laws. Such directors shall hold their offices for one year, or such other period as the By-Laws shall determine, or until their successors are duly elected and qualified. The names and places of residence of the persons to be the corporation's first Board of Directors are as follows:

Harry Janky
1814 N. W. 16th Street
Faribault, MN 55021

Alyce Heim
5345 Bryant Avenue South
Minneapolis, MN 55419

Sandra Kilde
11784 Madison Street N.E.
Blaine, MN 55434

Joy Majors
11784 Madison Street N.E.
Blaine, MN 55434

Dolores Ginsberg
226 Howard Gnesen Road
Duluth, MN 55811

Robert Steffenson
Route 1, Box 850A
Alexandria, MN 56308

Betty K. Nordine
1418 – 15th Avenue N.E.
Rochester, MN 55901

Beatrice Williams
5333 – 48th Avenue South
Minneapolis, MN 55417

John Benner
1807 N. W. Second Avenue
Austin, MN 55912

ARTICLE VIII

Duration

The duration of this corporation shall be perpetual.

ARTICLE IX

Dissolution

Upon the dissolution of the corporation, the Board of Directors shall, after paying or making provision for the payment of all of the liabilities of the corporation, distribute all assets of the corporation exclusively for the purposes of the corporation in such manner, or to such organization or organizations organized and operated exclusively for charitable, educational, religious, or scientific purposes as shall at the time qualify as an organization or organizations described in section 501 (c)(3) of the Internal Revenue Code of 1954, as the Board of Directors shall determine.

ARTICLE X

No Capital Stock

This corporation shall have no capital stock.

ARTICLE XI

Incorporators

The names and addresses of each incorporator of this corporation is:

Harry Janky
1814 N.W. 16th Street
Faribault, MN 55021

Sandra Kilde
11784 Madison Street N.E.
Blaine, MN 55434

Alyce Heim
5345 Bryant Avenue South
Minneapolis, MN 55419

ARTICLE XII

Construction

All references herein to provisions of the Internal Revenue Code of 1954 shall be deemed to include statutes which have succeeded such provisions as they are duly enacted by congress.

ARTICLE XIII

Amendment

These Articles may be amended in any manner now or hereafter prescribed by law, except that two-thirds (⅔) vote of the entire Board of Directors shall be required for the adoption of any amendment by the Board of Directors, either pursuant to authorization of the members or otherwise.

We, the incorporators, sign our names this 2nd day of April 1975.

In the Presence of:

/s/ Harry Janky
Harry Janky

/s/ Diane M. Laija

/s/ Sandra Kilde
Sandra Kilde

/s/ Cahler

/s/ Alyce Heim
Alice Heim

STATE OF MINNESOTA)
) SS
COUNTY OF HENNEPIN)

On this 2nd day of April, 1975, before me, a Notary Public within and for said County, personally appeared Harry Janky, Sandra Kilde, and Alyce Heim, to me known to be the persons described in and who executed for foregoing instrument and acknowledged that they executed the same as their own free act and deed.

/s/ Philip J. Haleen
Notary Public

[SEAL]
PHILIP J. HALEEN
NOTARY PUBLIC – MINNESOTA
HENNEPIN COUNTY
My Commission Expires Jan. 5, 1982

STATE OF MINNESOTA
DEPARTMENT OF STATE

I hereby certify that the within instrument was filed for record in this office on the 7 day of APRIL A.D. 1975,

at 8 o'clock A.M., and was duly recorded in Book M-43 of incorporations, on page 195

/s/ Joan Anderson Growe
Secretary of State

CERTIFICATE OF AMENDMENT OF
ARTICLES OF INCORPORATION

of

MINNESOTA ASSOCIATION OF
NURSE ANESTHETISTS

We, the undersigned ALYCE A. HEIM and THOMAS G. HEALEY, respectively the president and secretary of MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS, a non-profit corporation to hereby certify that at a (regular meeting of the members of said corporation) XX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, duly called and held in the City of MINNEAPOLIS on JANUARY 18, 1978 at EIGHT o'clock P.M., at which meeting a majority of the members were represented in person or by proxy, resolutions, as hereinafter set forth, were adopted by a majority vote of said members:

"RESOLVED that Articles VI, of the Articles of Incorporation of THE MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS be, and the same hereby (is)

(~~are~~) amended to read as follows:

ARTICLE VI

The location and Post Office address of the registered office of this corporation in the State of

Minnesota shall be 2353 Rice Street, North, c/o Carter/Locey and Associates, St. Paul, Minnesota 55113.

RESOLVED further that the president and secretary of this corporation be and they hereby are, authorized and directed to make, execute and acknowledge a certificate under the corporate seal of this corporation embracing the foregoing resolutions, and to cause such certificate to be filed and recorded in the manner required by law.

And we do further certify that the said resolutions, and said articles of incorporation so amended, were at a meeting of the board of directors, held on the 18th day of January, 1978 at which a majority of all the members of said board were present and voted, duly adopted, ratified.

IN WITNESS WHEREOF, we, the undersigned, have subscribed our names and caused corporate seal of said corporation to be hereto affixed this 5th day of February, 1978.

In presence of:

/s/ Alyce A. Heim
/s/ Thomas G. Healey

ALYCE A. HEIM
President
THOMAS G. HEALEY
Secretary

(Corporate Seal) NO CORPORATE SEAL

STATE OF MINNESOTA,

ss.

COUNTY OF HENNEPIN

ALCYE A. HEIM and THOMAS G. HEALEY being first duly sworn, on oath depose and say: that they are respectively the ___president and ___secretary of THE MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS, the corporation named in the foregoing certificate; that said certificate contains a true statement of the action of the members and board of directors of said corporation, duly held as aforesaid: (XXXXXXXXXXXXXXXXXXXXXXXXXX) (THAT THIS CORPORATION HAS NO CORPORATE SEAL) that said certificate is executed on behalf of said corporation, by its express authority; and they further acknowledge the same to be their free act and deed and the free act and deed of said corporation.

/s/ Alyce Heim President
/s/ Thomas G. Healey Secretary

Subscribed and sworn to before me this 23rd day of October 1977.

/s/ Charles F. Beecroft Notary Public
Hennepin County, Minnesota
My commission expires 12/17/1982

(Notarial Seal)

[SEAL]
CHARLES F. BEECROFT
NOTARY PUBLIC – MINNESOTA
HENNEPIN COUNTY
My Commission Expires Dec. 17, 1982

———

STATE OF MINNESOTA
DEPARTMENT OF STATE

I hereby certify that the within instrument was filed for record in this office on the 17 day of MARCH A.D. 1978, at 8 o'clock A.M., and was duly recorded in Book A-48 of incorporations, on page 946

/s/ Joan Anderson Growe
Secretary of State

[SEAL]

State of Minnesota
Office of the Secretary of State

CERTIFICATE OF CHANGE OF
REGISTERED OFFICE
by

Name of Corporation

Minnesota Association of Nurse Anesthetists

Pursuant to Minnesota Statues Section 301.33, 302A.123, or 317.19, the undersigned hereby certifies that the Board of Directors of the above named Minnesota corporation has resolved to change the corporation's registered office:

FROM
Address (No. & Street)
XXXXXXXXXX 2353 N. Rice St.
City XXXXXXXXXX Roseville
County XXXXXXXXXX Ramsey MN
Zip XXXXXXXXXX 55113

TO
Address (No. & Street)
University Technology Center, Suite 329 B
1313 – 5th Street S.E.
City Minneapolis County Hennepin MN
Zip 55414

The effective date of the change will be the 3rd day of November, 1988 or the day of filing of this certificate with the Secretary of State, whichever is later.

Name of Officer or Other Authorized Agent of Corporation

Lodemia R. Hartley
Signature
/s/ Lodemia R. Hartley
Title or Office President
Date November 14, 1988

REQUIRED FOR 302a CORPORATIONS ONLY

STATE OF MINNESOTA
County of Hennepin ss.

The foregoing instrument was acknowledged before me this 14th day of November, 1988.

/s/ Lois J. Oppen
Notary Public

(Notarial Stamp)
[SEAL]
Lois J. Oppen
NOTARY PUBLIC MINNESOTA
DAKOTA COUNTY
MY COMMISSION EXPIRES JUN 16, 1991

[SEAL]

STATE OF MINNESOTA
SECRETARY OF STATE
NOTICE OF CHANGE OF REGISTERED OFFICE/
REGISTERED AGENT

1. Corporate Name:

Minnesota Assn of Nurse Anesthetists

2. Registered Office Address (No. & Street): List a complete street address or rural route and rural route box number. A post office box is not acceptable.

7200 France Av. So. #230 Edina
Street City

MN 55435
State Zip Code

3. Registered Agent (Registered agents are required for foreign corporations but optional for Minnesota corporations):

NONE

If you do not wish to designate an agent, you must list "NONE" in this box. DO NOT LIST THE CORPORATE NAME.

In compliance with Minnesota Statutes, Section 302A.123, 303.10, 308A.025, 317A.123 or 322B.135 I certify that the above listed company has resolved to change the company's registered office and/or agent as listed above.

I certify that I am authorized to execute this certificate and I further certify that I understand that by signing this certificate I am subject to the penalties of perjury as set

forth in *Minnesota Statutes Section 609.48* as if I had signed this certificate under oath.

/s/ Steve Halls Treasurer
Signature of Authorized Person
Name and Telephone Number of a Contact Persons:

Steven C. Hendrickson (612) 571-6616
please print legibly

Filing Fee:
Minnesota Corporations, Cooperatives and Limited Liability Companies: $35.00.

Non-Minnesota Corporations: $50.00.

Make checks payable to

Secretary of State
Return to:

Minnesota Secretary of State
180 State Office Bldg.
100 Constitution Ave.
St. Paul, MN 55155-1299
(612) 296-2803

Office Use One

(Filed
Jun. 1, 1994)

[SEAL]

MINNESOTA SECRETARY OF STATE

AMENDMENT OF ARTICLES OF INCORPORATION

READ INSTRUCTIONS LISTED BELOW, BEFORE COMPLETING THIS FORM.

1. Type or print in black ink.
2. There is a $35.00 fee payable to the Secretary of State for filing this "Amendment of Articles of Incorporation".
3. Return Completed Amendment Form and Fee to the address listed on the bottom of the form.

CORPORATE NAME: (List the name of the company prior to any desired name change)

MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS EDUCATION & RESEARCH FOUNDATION

This amendment is effective on the day it is filed with the Secretary of State, unless you indicate another date, no later than 30 days after filing with the Secretary of State.

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format(mm/dd/yyyy)

The following amendment(s) to articles regulating the above corporation were adopted: (insert full text of newly amended article(s) indicating which article(s) is (are) being amended or added.) If the full text of the amendment will not fit in the space provided, attach additional numbered pages. (Total number of pages including this form I.)

ARTICLE I

The name of this corporation shall be Norm Paradise Nurse Anesthesia Education and Research Foundation.

This amendment has been approved pursuant to *Minnesota Statutes chapter 302A or 317A.* I certify that I am authorized to execute this amendment and I further certify that I understand that by signing this amendment, I am subject to the penalties of perjury as set forth in section 609.48 as if I had signed this amendment under oath.

/s/ Leslie A. Johnson RN, CRNA, MS
(Signature of Authorized Person)

Name and telephone number of contact person:
LESLIE A. JOHNSON (715) 262-0043
Please print legibly

All of the information on this form is public and required in order to process this filing. Failure to provide the requested information will prevent the Office from approving or further processing this filing.

If you have any questions please contact the Secretary of State's office at (651) 296-2803.

(Filed Dec. 11, 2001)

RETURN TO:
Secretary of State
180 State Office Bldg., 100 Constitution Ave.
St. Paul, MN 55155-1299, (651) 296-2803

STATE OF MINNESOTA
DEPARTMENT OF STATE

I hereby certify that this is a true and complete copy of the document as filed for record in this office.

DATED 1/25/2002
/s/ Mary Kiffmeyer
Secretary of State

[SEAL]
By Evan Hiltman

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
FOURTH DIVISION

UNITED STATES OF AMERICA, *ex rel.* MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS, Plaintiff, vs. ALLINA HEALTH SYSTEM CORP., et al. Defendants.	**Civil No. 4-96-734 ADM/JGL** **AFFIDAVIT OF MARY VICTORIA YARNS**

State of Minnesota)
) ss.
County of Hennepin)

Mary Victoria Yarns, being sworn, states as follows:

1. I am the Manager of Regulatory Billing for the Allina Health System Consolidated Business Office ("CBO").

2. "Medical necessity" cases are those procedures that the Medicare carrier (formerly known as Travelers and currently known as United Health Care), has designated as procedures for which the carrier will pay for two anesthesia providers, even if the anesthesiologist on the case bills the case as "one-on-one" or personally performed. The carrier has made the decision that these procedures, designated by nine CPT Codes, are sufficiently difficult or

complicated so as to require the services of two anesthesia providers. The relevant page from the March 1997 policy manual listing the nine CPT Codes is attached as an exhibit to this affidavit.

3. To the best of my knowledge and based on my personal experience, when Allina employed CRNAs at Unity and Mercy Hospitals, the CBO billed for CRNA services on Medicare medical necessity cases at Unity and Mercy under the "medically directed" modifier. Abbott Northwestern Hospital became part of Allina's predecessor, HealthSpan, in 1993. From 1993 until July, 1994, Abbott's CRNA charges were billed on a system separate from Unity and Mercy, but the practice would still be to bill Medicare medical necessity cases as medically directed. After July, 1994, Abbott's CRNA charges were billed on the same system as Unity and Mercy and, to the best of my knowledge and based on my personal experience, such charges were billed as medically directed in Medicare medical necessity cases.

/s/ Mary Victoria Yarns
Mary Victoria Yarns

[SEAL] PAMELA J. THORSEN
NOTARY PUBLIC MINNESOTA
My Commission Expires
Jan. 31, 2000

Subscribed and sworn to before me
this 31st day of July, 1998.

/s/ Pamela J. Thorsen
Notary Public

No. 123 SEPTEMBER 1993

MEDICARE NEWS

An Information Service From The Travelers Companies

The Travelers [LOGO]

Part B Medicare Office • 8120 Penn Ave. So. • Bloomington, MN 55431 • Mike Esterley, District Mgr. • Phone (612) 884-3030

REVISED TRANSITION SCHEDULE DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

The Health Care Financing Administration has announced that the transition of those DMEPOS claims originally scheduled for 10/1/93 has been postponed until 11/1/93. This affects residents of the State of Minnesota. We will continue to process DMEPOS claims received in our office prior to 11/1/03.

If you have specific questions regarding the postponement, please contact the Durable Medical Equipment Regional Contractor at 1-800-346-2233.

* * *

ANESTHESIA PAYMENT POLICIES

The Health Care Financing Administration Bureau of Policy and Development has issued the following payment policies. They were asked to clarify the policies that apply when: (1) the starting point of one anesthesia procedure and the ending point of a second anesthesia procedure as the same for medically directed anesthesia procedures; and (2) an anesthesiologist and a certified registered nurse

anesthetist (CRNA) are both involved in a single anesthesia procedure. This is their response:

We would recognize two concurrent procedures if there are two anesthesia procedures, each of which is being performed by a CRNA, and the ending point of procedure A is the same as the starting point of procedure B. If, for example, an anesthesiologist is involved with two procedures, and one anesthesia procedure ends at 10:00 while the second procedure begins at 10:00, then we will consider this case to be two procedures medically directed by the anesthesiologist. Thus, these procedures would be reported with the QJ modifier and not the AA modifier used for personally performed procedures. Consequently, each of these procedures would be subject to the 10 percent base unit reduction and would be permitted half the time units of a personally performed procedure.

Under the regulations, an anesthesia procedure is considered personally performed by the physician if the physician is continuously involved in a single case with a CRNA. No payment is made under the CRNA fee schedule for the services of the CRNA unless it is determined that it was medically necessary for the CRNA to be involved in the case.

It has been reported that anesthesiologists will bill using the AA modifier even though they are outside the operating room performing other activities, such as pain blocks, doing pre or post operative evaluations, or administering and/or monitoring a labor epidural. For the anesthesiologist to bill using the AA modifier under these circumstances, he must be physically present in the operating suite while the CRNA is attending to the case. If the anesthesiologist is not continuously involved with the

case, then it is considered neither personally performed nor medically directed. The carrier has the discretion to determine how much to recognize for the CRNA service based on the fact that part of the time the CRNA's services are overseen by the anesthesiologist and the remainder of the time, the CRNA is functioning as a nonmedically directed CRNA.

MEDICARE Newsletter [LOGO] BlueCross BlueShield of Minnesota

For Part B Providers April 1994 Number 44

Your Monthly Update of Medicare News

THE MEDICAL DIRECTOR'S COLUMN

By Jack W. Alexander, M.D.
Medicare Medical Director

Title: Diagnostic Mammography

This newsletter article is going to be brief but I want the chance to mention several things. First, I have revised the Diagnostic Mammography policy that was printed in the last newsletter. The policy that was published last month was a description of the national coverage guidelines and the ICD-9 codes that we have been using in the past. After publication, I realized that some changes were necessary. The most significant changes include the addition of diagnostic codes for secondary malignant neoplasms, neoplasms of uncertain behavior, and a "V" code for asymptomatic patients.

The reason for the addition of the secondary malignancy codes and the malignancy of uncertain behavior is that physicians often order mammograms on women who present with this clinical scenario. The purpose is to exclude breast cancer as the primary malignancy.

I added the "V" code. V76.1, to allow you to bill for the situation described by the third bullet in the "Description" section of the policy. In circumstances where the physician recommends a mammogram for reasons or diagnoses other than those listed in the policy this ICD-9 code should be used.

CAC Meeting

Our Carrier Advisory Committee meeting was held here at Blue Cross on February 17, 1994. Attendance was good and we had lively discussions on a number of topics. I presented two new policies which opened the comment. The policies include "Cardiac Event Recorder (93625)" and "Prostate Specific Antigen (3415)". If you are interested in receiving copies of these policies during the comment period please contact your CAC representative or contact me directly (see below).

Duluth Visit

On February 28th Pat Heald, Lori Ellis, and I had the opportunity to visit the Duluth Clinic. We spoke with physicians, clinic administrators, and billing personnel. We feel the meeting was very productive and helped us understand each others concerns. If you are interested in having us visit your clinic please feel free to contact me. You can reach me either at the address on this Newsletter or by phone at 612-456-1340.

MEDICARE FEE SCHEDULE CHANGES

The following changes have been made to the Medicare Fee Schedule Data Base. These changes will be effective April 1, 1994.

Procedure Changes

52332 Bilateral surgery indicator changed from a "O" to "1" – Payment adjustment for bilateral procedures applies if code is billed with the bilateral modifier (-50). Payment based on the lower of the billed

amount or 150% of the Medicare fee schedule amount.

69210 Bilateral surgery indicator changed from a "O" to "2" – Payment adjustment for bilateral procedures does not apply. RVUs are based on the procedure being performed as a bilateral procedure. Procedures in this category include services for which the code descriptor specifically states that the procedure is bilateral: procedures that are usually performed as bilateral procedures; or procedures for which the code descriptor indicates the procedures may be performed either unilaterally or bilaterally. Payment is based on the lower of the billed amount or the Medicare fee schedule amount.

92985 Global Period changed from "0" to "90" – days.

ANESTHESIA PAYMENT POLICIES: CLARIFICATION

The Health Care Financing Administration (HCFA) recently issued clarification in regard to the policies that apply when: (1) the starting point of one anesthesia procedure and the ending point of a second anesthesia procedure are the same (or medically directed anesthesia procedures; and (2) an anesthesiologist and a CRNA are both involved in a single anesthesia procedure.

1) Two concurrent procedures are recognized if there are two anesthesia procedures each of which is being performed by a CRNA, and the ending point of procedure A is the same as the starting point of procedure B. If, for example, an anesthesiologist is involved with two procedures, and one anesthesia procedure ends at 10:00 a.m. while the second procedure begins at 10:00

a.m., this case would be considered to be two medically directed procedures (reported with the "QJ" modifier).

2) Under federal regulations, an anesthesia procedure is considered personally performed by the physician if the physician is continuously involved in a single case with a CRNA. No payment is made under the CRNA fee schedule for the services of the CRNA unless it is determined that it was medically necessary for the CRNA to be involved in the case.

It has been reported that some anesthesiologists have billed using the "AA" modifier even tough [sic] they are outside the operating room performing other activities, such as pain blocks, doing pre- or post-operative evaluations, or administering and/or monitoring a labor epidural. For the anesthesiologist to bill using "AA" modifier under these circumstances, he or she must be physically present in the operating suite while the CRNA is attending to the case. If the anesthesiologist is not continuously present in the operating suite while the CRNA is attending to the case, then it is considered neither personally performed nor medically directed. In these instances, the anesthesiologist may not bill using the AA modifier. The CRNA may bill for the service as personally performed (QZ).

If an anesthesiologist has been paid for personally performing an anesthesia service when he or she was not continuously present, and the CRNA's claim was denied, payment may be made to the CRNA if it is brought to our attention that the anesthesiologist was not continuously present during the single procedure. Please attach any supporting documentation, including the anesthesia log

and a statement that the anesthesiologist was not continuously present.

[LOGO]
HealthSpan

March 12, 1993

Mr. Patrick Donohue
The Travelers
8120 Penn Ave. South
Bloomington, MN 55431

RE: Anesthesia Reimbursement

Dear Mr. Donohue:

The purpose of this letter is to confirm with you prior discussions relating to the standards for billing for the services of anesthesiologists (MDAs) and anesthetists (CRNAs). HealthSpan hospitals have received several letters in the past in which you requested to be reimbursed for payments previously made by the medicare program to the hospital on the grounds that the MDAs had billed and received payment for those services and that consequently the hospital should not have billed for the CRNA services. In an effort to ensure compliance with the appropriate Medicare rules and regulations and clarify any misunderstandings that may exist with respect to billing, I will set forth our understanding – based on previous conversations with you and other government entities or representatives – of the billing process.

As a general rule, an MDA may only be paid for services in one of two settings. The first scenario involves the personal delivery of the service by the MDA. The second involves the activity of the MDA in supervising (medical direction) two to four concurrent procedures in which the CRNAs deliver much of the service and the MDAs supervise the SRNAs and assist in the most difficult aspects of the anesthesia procedure.

The hospital is not entitled to reimbursement in those situations which the MDA personally delivered the service (1:1) even if the CRNA assisted in the process. The only exception to this rule is in exceptionally difficult cases that require the services of both the MDA and the CRNA. In this situation, the MDA would be able to bill for personally delivering the service and the hospital would be entitled to be reimbursed for the CRNA services.

The difficult question comes in determining when the MDA has personally delivered the service.

It is our understanding that in order to qualify for reimbursement for the personal delivery (1:1) of a service, the MDA must be "continuously present with the CRNA (if a CRNA is also involved) for those services the anesthesiologist does not personally perform, and the anesthesiologist can not be involved in any other anesthesia procedure." This means that the anesthesiologist either must personally perform all of the services related to the anesthesia procedure (including the history and physical, the induction, the monitoring, the emergence and other activities related to the anesthesia) or the MDA must have been continuously present in the operating room if the CRNA delivered any services. If the MDA does not perform all of the services or remain continually present in the operating room, the MDA has not personally delivered the service and is not entitled to bill for the service on a 1:1 basis because the service was not personally delivered. It should also be noted that the MDA is not entitled to bill for supervising a CRNA in this instance unless there was a concurrent case.

The anesthesiologist is also entitled to reimbursement on a reasonable charge basis for medical direction of CRNAs

furnished in concurrent procedures. In order to qualify for reimbursement for medical direction on concurrent cases, the MDA must (1) perform a pre-anesthesia examination and evaluation; (2) prescribe the anesthesia plan; (3) personally participate in the most demanding procedures in the anesthesia plan, including indiction and emergence; (4) insure that any procedure in the anesthesia plan that he or she is performed by qualified individuals (CRNAs); (5) monitors the course of anesthesia administration at frequent intervals; (6) remains physically present and available for immediate diagnosis and treatment of emergencies; and (7) provides indicated post-anesthesia care. If the foregoing criteria are not met, the MDA should not be billing for concurrent supervision.

It should also be noted that anesthesiologists who are part of a group practice may fill different components of the foregoing concurrent supervision reimbursement requirements and personal delivery requirements. However, the medical record must indicate that the services were rendered by physicians and identify the specific physicians or MDAs who rendered the services.

While I believe that the foregoing accurately reflects the state of the law, I would like to provide several examples and our conclusions with respect to how these should be billed. Please indicate whether or not you agree with our conclusions.

Example 1:

Procedure A and Procedure B both begin at 8:00 A.M. in adjoining operating rooms. A single MDA supervises the administration of the anesthetic by the CRNAs, participates in the most difficult portions of the anesthesia plan, including induction and emergence, monitors the course of

administration at frequent intervals and remains physically present in the operating suite to be immediately available in either operating room for the immediate diagnosis and treatment of emergencies.

It is our understanding that in the foregoing situation, the MDA would be entitled to bill for medical direction of the CRNAs. In addition, the hospital would be entitled to reimbursement for the CRNA services.

Example 2:

The activities performed by the MDA and the CRNA are the same as in Example 1 but there is no Procedure B occurring. Only Procedure A is being done meaning that there is only one operating room and one surgery.

In assuming that the same level of services were provided as above, it is our understanding that the MDA would not be permitted to bill for the service because (1) the MDA did not personally deliver the service, and (2) there were no concurrent procedures. In this situation, the hospital would be entitled to bill for the CRNA services but the MDA would not be entitled to bill at all.

Example 3:

The facts are the same as in Example 1 only the MDA's participation in the process is limited to performing the pre-anesthesia examination and evaluation prior to the procedure, remaining in the operating suite (as opposed to being continuously in the operating room), and monitoring the patient in the recovery room.

In this situation, the MDA would not be entitled to bill because the MDA did not fulfill all the requirements for supervision.

Example 4:

There is a single procedure in which both the MDA and the CRNA are continuously present. The MDA remains in the operating room and a continual active participant in the delivery of the anesthesia service throughout the operation. This is not a particularly difficult case and the service could have been provided without the assistance of the CRNA.

In the foregoing situation, it is our understanding that the MDA has personally delivered the service because he has remained continuously present in the operating room and/or actually performed most of the anesthesia services. Since the procedure was not a difficult one, the hospital is not entitled to the reimbursement for the CRNA services even though the CRNA may have assisted the MDA in various aspects of providing the anesthesia.

Example 5:

The facts are the same as in Example 4 except for this is an extremely difficult procedure requiring the services of both the MDA and the CRNA.

In this situation, the MDA would be entitled to bill one-to-one for personal delivery of the services, and the hospital would also be entitled to be reimbursed for the CRNA services.

Example 6:

Procedure A commences at 8:00 A.M. in operating room 1. The MDA is not personally delivering the service but rather is supervising the delivery of the service. Procedure A ends at 10:00 A.M. Procedure B commences in the adjoining operating room at 9:55 A.M. Again, the MDA is

not personally delivering the services but rather is supervising a CRNA who actually provides most of the service.

In this situation, the MDA would again not be entitled to payment for the service or supervision because the cases were not considered concurrent. Our understanding is that concurrency does not exist if there is five or less minutes of overlap of the cases. However, if the facts were the same as above but Procedure B started at 9:50 rather than at 9:55, the procedures would have been viewed as concurrent and the MDA would have been entitled to bill for concurrent supervision of the two cases.

Please review this letter carefully and respond with your conclusions relating to the accuracy or correctness of our interpretation of appropriate billing procedures. It is only after we have a clear understanding of how you interpret the billing requirements for anesthesia services that we can move to correct any deficiencies in the billing process that might exist.

If you have questions with regard to this matter, please feel free to call me at 612-574-7738.

Sincerely,

HEALTHSPAN HEALTH
SYSTEMS CORPORATION

/s/ Daniel R. Roach
Daniel R. Roach
Senior Attorney

MEDICARE

March 25, 1993

Daniel R. Roach
Senior Attorney
HealthSpan
2810 57th Avenue North
Minneapolis, MN 55430

Dear Mr. Roach:

I have received your letter of March 12, 1993 regarding "Anesthesia Reimbursement".

Your understandings of MDA and CRNA Medicare billing rights are essentially correct with one clarification. Instances where an MDA and a CRNA are both involved in a single case with no concurrency, the MDA's obligation is continuous involvement with the procedure, rather than, continuous presence with the CRNA as cited in your letter. Continuous involvement carries the same requirement as medical direction, one of which is that the MDA be present in the operating suite and available for diagnosis and treatment of emergencies.

Having made the above clarification, I offer my responses to your examples. My responses all assume that the MDA has met the medical direction requirements of personal performance of a pre-anesthesia exam and evaluation, prescription of the anesthesia plan, participation in the most demanding procedures of the anesthesia plan including induction and emergence, monitoring the course of anesthesia administration at intervals and providing indicated post-anesthesia care.

Example 1: I agree with your conclusion.

Example 2: I disagree with your conclusion because the MDA remained personally involved having rendered the required personal services and medically-directed delivery of the others.

Example 3: I agree with your conclusion, The MDA was deficient in not having personally participated in the most demanding procedures of the anesthesia plan including induction and emergence and in not having monitored the course of anesthesia administration at intervals.

Example 4: I agree with your conclusion.

Example 5: I agree with your conclusion and, as long as we (the Medicare Carrier), concur with the medical need for both participants, both Medicare claims will be covered.

Example 6: I disagree with your conclusion because concurrency is defined in terms of any overlap. In either of the timeframes that you cited, two concurrent procedures are involved and should be billed by the MDA accordingly.

I hope that my letter helps to achieve the clear understanding of anesthesia reimbursement that you seek. If more information is needed, please contact me again.

Yours truly,

/s/ Patrick Donohue
Patrick Donohue
Unit Manager

PD:dv

From: GE86 – HCFACHI Date and time 07/27/93 10:11:43
To: 00621E – HCFACHI 00103E – HCFACHI
007102E – HCFACHI 00220E – HCFACHI
10240E – HCFACHI 00951E – HCFACHI
16360E – HCFACHI

From: JIM CUCA
Policy Specialist/COB
(312) 353-3822

Subject: Anesthesia Procedures – CO Memorandum

We are sending to you via PROPS a memorandum from BPD which clarifies the policies involving two anesthesia scenarios: (1) one anesthesia procedure begins at the same time a second procedure begins; (2) an anesthesiologist and a CRNA are both involved in the same procedure. The file name for the memo is NESFOLL.WF.

If there are any questions, please call me at (312) 353-3822 or Alice Wiley at (312) 353-9851.

cc: GK40 – HCFACHI Arney, Steve

GK40 – HCFACHI Arney, Steve

CC: ADMINISTRATIVE
PERSONNEL

REFER TO: FQA-541

Director
Office of Payment Policy, BPD

Anesthesia Payment Policies

All Associate Regional Administrators
for Medicare

We have been asked to clarify the policies that apply when: (1) the starting point of one anesthesia procedure and the ending point of a second anesthesia procedure are the same for medically directed anesthesia procedures; and (2) an anesthesiologist and a certified registered nurse anesthetist (CRNA) are both involved in a single anesthesia procedure.

We would recognize two concurrent procedures if there are two anesthesia procedures each of which is being performed by a CRNA, and the ending point of procedure A is the same as the starting point of procedure B. If, for example, an anesthesiologist is involved with two procedures, and one anesthesia procedure ends at 10:00 while the second procedure begins at 10:00, then we will consider this case to be two procedures medically directed by the anesthesiologist. Thus, these procedures would be reported with the QJ modifier and not the AA modifier used for personally performed procedures. Consequently, each of these procedures would be subject to the 10 percent base unit reduction and would be permitted half the time units of a personally performed procedure.

Under the regulations, an anesthesia procedure is considered personally performed by the physician if the physician is continuously involved in a single case with a CRNA. No payment is made under the CRNA fee schedule for the services of the CRNA unless it is determined that it

was medically necessary for the CRNA to be involved in the case.

It has been reported that anesthesiologists will bill using the AA modifier even though they are outside the operating room performing other activities, such as pain blocks, doing pre or post operative evaluations, or administering and/or monitoring a labor epidural. For the anesthesiologist to bill using the AA modifier under these circumstances, he must be physically present in the operating suite while the CRNA is attending to the case. If the anesthesiologist is not continuously involved with the case, then it is considered neither personally performed nor medically directed. The carrier has the discretion to determine how much to recognize for the CRNA service based on the fact that part of the time the CRNA's services are overseen by the anesthesiologist and the remainder of the time, the CRNA is functioning as a nonmedically directed CRNA.

Charles R. Booth

cc:
Stewart Streimer, BPO
Office of Issuances
Field Operations

FQA-541:JMPNAS/x64507:TRINA/x65702
DATE: 7/15/93/FINAL:
DISC:TRINA#3/DOC:ANESFOLL.JME/FILE
CODE:CRNA
CATCS Control #:

ProSTAT

ResourceGroup

ANALYSIS OF

CARRIER CORRESPONDENCE

February 1997

Prepared by:

Brenda Morrow

ProSTAT

Resource Group

6900 College Boulevard • Suite 1000

Overland Park, Kansas 66211

(913) 663-5588

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

Personal Background

I, Brenda Morrow of ProSTAT Resource Group, prepared this study. My experience related to Medicare Part B issues includes employment by Blue Cross and Blue Shield of Kansas City in its Medicare Part B division from 1980-1986. During that time, I was involved in multiple aspects of Medicare claims processing and ended my tenure there as Manager of Claims Processing. Since 1986, I have

worked as a consultant to physicians and other health care providers on Medicare Part B and other insurance billing issues. In this capacity, I have worked with anesthesia practices on billing and compliance issues. I am editor of an anesthesia newsletter, *Perspectives,* and co-author of an anesthesia text, *Getting Paid for Anesthesia.*

I have been associated with ProSTAT since its inception in 1990 and am currently Director of Special Projects. My curriculum vitae is included as Attachment 5 to this report. I have been retained by defense counsel in litigation involving CRNAs in Federal District Court in Minnesota.

Scope of the Study

The purpose of this study was to determine how the Health Care Financing Administration's (HCFA) guidelines regarding payment for anesthesia services provided when an anesthesiologist and a CRNA are involved in a single case have been conveyed by Medicare Part B carriers to physicians and other providers.

To begin this study, I prepared a written request for copies of all Carrier's Manual provisions, provider bulletins, newsletter articles or other written communication related to anesthesia billing and reimbursement issues that were issued to the physician and/or provider community from January 1, 1989, forward. This request was sent to all Medicare Part B carriers and was made in accordance with the provisions of the Freedom of Information Act (FOIA).

A copy of the written FOIA request and a list of all carriers to whom it was sent are shown as Attachment 1 to

this report. FOIA requests were sent to the 40 insurance companies listed as Medicare Part B carriers in HCFA's 1995 *Intermediary and Carrier Directory*. Of these 40 carriers, two are no longer active Part B carriers (Blue Cross Blue Shield of Minnesota and Aetna in New Mexico) and one did not respond at all (Blue Cross and Blue Shield of Arkansas). The remaining 37 carriers (97%) have responded to the FOIA request as of the date of this report.

As responses were received, I noted that a significant number of unrelated carriers published articles in late 1993 related to billing for medical direction of a CRNA on a single case. These individual newsletter articles were similar enough to indicate that they were based on communication from the Health Care Financing Administration and were not independently developed by each carrier. To verify this, I sent a second FOIA request to each of these carriers to obtain copies of the HCFA communication or other source document that was the basis for the articles.

A copy of the second written FOIA request and a list of all carriers to whom it was sent are shown as Attachment 2 to this report. FOIA second requests were sent to 16 carriers and 14 responses (88%) have been received as of the date of this report. (Responses from CIGNA for the states of North Carolina and Idaho were provided by CIGNA in Tennessee.)

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

These responses are sufficient to indicate that the fall 1993 carrier bulletins were derived from a July 1993 memorandum from Charles Booth at HCFA's Central Office. This memo was sent to the Associate Regional Administrators at HCFA's Regional Offices. The Regional Offices then distributed the information to many, if not all, of the Part B carriers. Attachment 3 includes a copy of the July 1993 HCFA memorandum and several examples of carrier bulletins that are derivatives of that memo.

Responses to both FOIA requests were evaluated on a carrier-by-carrier basis to determine whether the carrier provided instructions to physicians regarding how anesthesia services provided when an anesthesiologist and a CRNA are involved in a single case are to be reported by the physician and/or paid by the carrier. Responses from carriers who did address this issue in their physician correspondence were further evaluated to determine whether their instructions and policies were consistent from carrier to carrier.

Detail of the instructions provided by the carriers who addressed this issue are shown as Attachment 4 to this report.

Findings

1. Between 1989 and the date of our survey (late 1996), 33 of the 37 carriers (89%) who responded to our initial FOIA request conveyed guidelines to physicians related to billing for the situation in which a physician and a CRNA are both involved in a single

case. Four carriers apparently did not provide any newsletter guidelines related to this issue (Blue Cross Blue Shield of Kentucky, Blue Cross and Blue Shield of Rhode Island, General American Life Insurance Company [Missouri] and Triple-S [Puerto Rico]).

2. Between 1989 and the fall of 1993, at least 18 of the 37 carrier responses (49%) contained guidelines for billing services provided by a physician and a CRNA in a single case. Most of this correspondence reflects a portion of the Medicare Carriers Manual instruction at Section 8310.B which says, "Where an anesthesiologist and an anesthetist are both involved in a single anesthesia service, the service is consthesiologist. No separate payment is ordinarily recognized for the anesthetist's service." None of these carriers expanded on the definition of the term "involved."

   The language of Section 8310.B is reflected in pre-September 1993 correspondence from:

   - Aetna (Georgia)
   - IASD (Iowa)
   - Blue Cross and Blue Shield of Kansas
   - Travelers [now MetraHealth] (Minnesota)
   - Travelers [now MetraHealth] (Mississippi)
   - CIGNA (North Carolina)
   - Nationwide (Ohio)
   - Aetna (Oklahoma)

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

- Blue Cross and Blue Shield of Pennsylvania [now XACT Medicare Services]
- CIGNA (Tennessee)
- Blue Cross and Blue Shield of Texas
- Travelers [now MetraHealth] (Virginia)
- Aetna (Washington)

Pre-September 1993 correspondence from four additional carriers did not reflect Section 8310.B verbatim. These carriers, however, indicated that *supervision, direction* or *medical direction* of one CRNA was considered to be a service personally performed by the physician. These carriers include: WPS Health Insurance (Wisconsin), Aetna (Arizona/Nevada), CIGNA (Idaho), and Aetna (OR, AK).

The response from Blue Shield of California was the only one that included pre-1993 guidelines that the physician must be "personally and continuously involved" in delivering a service in order to bill for it as personally performed. This statement was published in early 1992 and corresponds to HCFA's addition of Section 15018.B to the Medicare Carriers Manual following implementation of the physician fee schedule. Section 15018.B states that "(Payment at Personally Performed Rate) . . . if . . . the physician was personally and continuously involved in a single anesthesia procedure performed by a . . . CRNA. . . ."

3. Twenty-two of the 37 responding carriers (59%) plus non-responding Blue Cross and Blue Shield of Minnesota (as shown in documents supplied to us by defense counsel) have published statements since 1989 that indicate that payment will be made at the personally performed rate to an anesthesiologist who medically directs or supervises a CRNA, or is assisted by a CRNA, on a single case. Twelve of these 23 carriers (52%) published such statements in 1995 and 1996. Table 1 on the next two pages lists the carriers who have published post-1989 references indicating that payment at the personally performed rate will be made to the anesthesiologist for "medical direction" or "supervision" of a CRNA on a single case. Complete details of each article referred to can be found in Attachment 4.

Table 1: Medical Direction/Supervision of a CRNA on a Single Case/Personally Provided Service

Carrier	*Date*	*Statement*
1. Blue Cross Blue Shield (AL)	April 1996	"If the anesthesiologist ... supervises only one CRNA, the AA modifier is used and the anesthesiologist receives the entire Medicare payment ..."
2. Aetna (AZ/NV)	Spring 1993 October 1995	"Anesthesia services ... involving the direction of only one anesthetist is considered to be personally performed ..."
	Spring 1993	"No claim should be filed for CRNA/AA services where only one CRNA/AA is directed. This is considered to be personally

		performed by the physician, only the physician should bill.
	July 1995	"AA ... Direction of one anesthetist/resident CRNA ... "
	October 1995	"When an anesthesiologist and an anesthetist are both involved in a SINGLE anesthesia service, the service is ... performed by the anesthesiologist ... "
	October 1995 1996	"Anesthesia services ... involving physician direction of only one anesthetist are reported by ... Modifier AA."
3. Blue Cross Blue Shield (CA)	Undated	"Medically directed: Use the medically directed conversion factor to determine payment where the anesthetist is medically-directed by an anesthesiologist as follows: "Where an anesthesiologist and an anesthetist are both involved in a single anesthesia service, the service is considered personally performed by the anesthesiologist ... "
4. Transamerica (CA)	September 1995	"Charges for the medical direction of CRNAs ... paid to, the physician anesthesiologist. Both CRNA/AA charges and anesthesiologists charges MAY be payable for the same procedure ... "

		September 1995	"Use one of the following modifiers to indicate the role of the billing physician . . . : AE – Anesthesiologist directed one anesthesia service"
5.	Aetna (Georgia)	Undated	"If a physician directs only one anesthetist, the claim should be billed as though the physician were rendering the service himself . . . "
		July 1995	"AA . . . Direction of one anesthetist/resident CRNA . . . "
6.	Aetna (Hawaii)	July 1995	"AA . . . Direction of one anesthetist/resident CRNA . . . "
7.	CIGNA (Idaho)	March 1993	"AA – Physician personally performed. (Also use AA when the anesthesiologist medically directs only one CRNA.)"
8.	IASD (Iowa)	June 1993	"AA – indicates . . . supervision of one CRNA."
9.	C & S (ME. NH. VT. MA)	July 1996	"If an anesthesiologist supervises only one CRNA performing one anesthesia session, Medicare pays the anesthesiologist as . . . personally performed . . . "
		November 1993	"Under the regulations, an anesthesia procedure is considered personally performed by the physician if

		said physician is continuously involved in a single case with a CRNA .... Anesthesiologists should bill using the AA modifier although they are outside the operating room . . . "
10. Blue Cross Blue Shield (MN)	June 1992	"Medical Direction of One CRNA: Supervision of one . . . CRNA . . . is considered to have been personally performed on the part of the physician . . . "
	January 1993	"Supervision of CRNA in a Single Case: Supervision of one CRNA . . . is considered to have been personally performed on the part of the physician . . . "
11. Blue Cross Blue Shield (Montana)	December 1994 May 1994 May 1995 May 1996	"If a physician directs only one CRNA . . . in a single procedure . . . the physician should bill as if he personally performed the procedure . . . " "Prior to 1996, . . . where an anesthetist and a anesthesiologist are both involved in a single anesthesia service, the service is considered personally performed by the anesthesiologist . . . "
12. Empire Medicare Services (New York)	1996	"The physician . . . will be paid at the personally performed rate if . . . the physician medically directed one CRNA."

		"... Medical supervision of one CRNA must use modifier 'AA'."
		"AA – ... medical direction of one CRNA ..."
13. CIGNA (NC)	August 1991	If an anesthesiologist ... supervises only one CRNA during the entire procedure, he may use an 'AA' modifier ... Regulations state that the anesthesiologist must be in the immediate vicinity and available to the CRNA ..."
	March 1993	"... Also use AA when anesthesiologist medically directs only one CRNA."
14. Nationwide (OH/WV)	September 1989 January 1996	"Medical direction of One Anesthetist – When an anesthesiologist and an anesthetist are both involved in a single anesthesia service ..."
15. Aetna (OK/NM)	July 1995	"AA ... Direction of one anesthetist/resident CRNA ..."
16. Aetna (Oregon, Alaska)	January 1989 January 1996	"When the anesthesiologist directs only one CRNA, the anesthesiologist will be reimbursed 1 unit for every 15 minutes, no reimbursement will be made for the CRNA's services ..."
	July 1995	"AA ... Direction of one anesthetist/resident CRNA ..."

17. XACT (PA)	October 1987	"Anesthesia Procedure Performed Personally by Physician – . . . the same 15-minute time unit intervals apply when an anesthetist assists the physician in the care of a single patient."
18. CIGNA (TN)	March 1993	"AA – . . . Also use AA when the anesthesiologist medically directs only one CRNA."
19. Blue Cross Blue Shield of Texas	January 1992	" . . . If an anesthetist assists the physician in the care of a single patient, the service is considered personally performed by the physician . . . "
20. Blue Cross Blue Shield of Utah	September 1995	" . . . when an anesthesiologist is directing only one CRNA, only the anesthesiologist can bill and be paid . . . "
	July 1996	" . . . if the anesthesiologist is directing only one CRNA, only the anesthesiologist will file a claim to Medicare. The anesthesiologist would need to reimburse the CRNA."
21. Metra-Health (VA)	March 1993	"Modifier 'AA' billed by the anesthesiologist indicates that . . . they medically directed only one CRNA . . . "
22. Aetna (Washington)	March 1989	"The following modifiers must be used with physicians services . . . AC – Medical direction of one procedure . . . "

	October 1989	" . . . Supervision of 1 CRNA
23. WPS (Wisconsin)		. . . is considered to have been personally performed on the part of the physician."
	January 1991	"When an anesthesiologist is medically directing one CRNA . . . the service is considered personally performed by the anesthesiologist . . . "

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

4. In the fall of 1993, sixteen of the responding carriers published articles that were based on a HCFA memorandum to HCFA regional administrators in July 1993. This memo was in turn conveyed from the regional offices to the local Medicare Part B carriers. These guidelines are:

> "Under the regulations, an anesthesia procedure is considered personally performed by the physician if the physician is continuously involved in a single case with a CRNA. No payment is made under the CRNA fee schedule for the services of the CRNA unless it is determined that it was medically necessary for the CRNA to be involved in the case.
>
> "It has been reported that anesthesiologists will bill using the AA modifier even though they are outside the operating room performing other activities, such as pain blocks, doing pre or post operative evaluations, or administering and/or monitoring a labor epidural. For the anesthesiologist to bill using the AA modifier under these circumstances, he must be physically present in

the operating suite while the CRNA is attending to the case. If the anesthesiologist is not continuously involved with the case, then it is considered neither personally performed nor medically directed. The carrier has the discretion to determine how much to recognize for the CRNA service based on the fact that part of the time the CRNA's services are overseen by the anesthesiologist and the remainder of the time, the CRNA is functioning as a nonmedically directed CRNA."

Table 2 lists ten carriers who reprinted the July 1993 HCFA memorandum in their newsletters in late 1993. These carriers did not expand on the HCFA memo or apply interpretive guidelines. None of the 37 responding carriers, including the ten in Table 2, have defined "continuously involved," "operating room" or "operating suite" in any of the correspondence with physicians which they supplied to us. (Non-responding Blue Cross and Blue Shield of Minnesota, in documents provided by defense counsel, reprinted the July 1993 HCFA memo in its April 1994 newsletter, omitting the material concerning "carrier discretion.")

Table 2: Carriers Reprinting the July 1993 HCFA Memorandum

Carrier	*Entire HCFA memo reprinted*	*"Carrier discretion" omitted*	*Carrier comment added*
Blue Cross Blue Shield (Alabama)	Yes	No	No
MetraHealth (Connecticut)	Yes	No	No
CIGNA (Idaho)	No	Yes	No
IASD (Iowa)	Yes	No	No

MetraHealth (Mississippi)	No	Yes	No
MetraHealth (Minnesota)	Yes	No	No
Blue Cross Blue Shield of Western NY	Yes	No	No
CIGNA (North Carolina)	No	Yes	No
Palmetto (South Carolina)	Yes	No	No
MetraHealth (Virginia)	Yes	No	No

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

Five other carriers published the 1993 HCFA memorandum but altered it and/or added locally-developed interpretation:

- Health Care Service Corporation (Illinois) altered the HCFA statement by eliminating the sentence that begins. "For the anesthesiologist to bill using the "AA" modifier under these circumstances . . . " and concluded that "if the anesthesiologist is not continuously involved with the case, it is considered neither personally performed nor medically directed." The carrier does not state whether it considers "continuously involved" to mean the physician is continuously present in the operating room as opposed to continuously present in the operating suite.

- Blue Cross Blue Shield of North Dakota altered the HCFA statement by paraphrasing it and concluding that HCFA's statement that "if the anesthesiologist is not continuously involved with the case, then it is considered neither personally provided nor medically directed" means that anesthesiologists are not to use

modifier AA if they are outside the operating room during the case.

- AdminiStar Federal (Indiana) explicitly prohibited physicians from billing for personally provided services unless they were personally present in the operating room from induction to emergence. AdminiStar was the only carrier to publish an extensive variation of the HCFA text.

- XACT Medicare Services, the carrier for Pennsylvania, changed the term "operating suite" to "operating room" and indicated that the statement meant that a personally provided service (modifier AA) could be reported only when the anesthesiologist did not leave the operating room.

- C & S Administrative Services, the carrier for Maine, New Hampshire, Vermont and Massachusetts, printed only the first paragraph of the HCFA memo and indicated that "Anesthesiologists should bill using the AA modifier although they are outside the operating room performing activities such as: pain blocks, pre- or post-operative evaluations . . . For the anesthesiologist to bill using the AA modifier under these circumstances, he/she must be physically present in the operating suite while the CRNA is attending the case . . . ".

Blue Cross and Blue Shield of Florida published in its September/October 1993 carrier bulletin an instruction to providers related to the use of the AA modifier that may have been based on the July 1993 HCFA memorandum due to its timing. The Florida carrier was not able to supply the source document for this article, however, because the document apparently had been destroyed in a fire.

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

Summary

1. Prior to the fall of 1993, 49% of the carriers responding to this survey had notified physicians of the provisions of Section 8310.B. of the Medicare Carriers Manual either verbatim or in substance. These carriers indicated that if an anesthesiologist was "involved in," "medically directed," "directed," or "supervised" a CRNA in a single case, payment was to be made to the anesthesiologist at the personally performed rate.

   The remaining responding carriers did not provide copies of pre-September 1993 correspondence related to this issue.

2. Section 15018.B supplemented Section 8310.B in the Carriers Manual in 1992. At that time, only one carrier among those responding discussed the change from "involvement" to "personal and continuous involvement" in connection with an anesthesiologists' duties in a 1:1 case.

3. Prior to the fall of 1993, there were no references noted to personal and continuous presence in the operating *room* as a requirement for deeming that the anesthesiologist personally provided the service when the anesthesiologist and an anesthetist were both involved in a single anesthesia service.

4. A July 1993 HCFA Central Office memorandum to all HCFA Associate Regional Administrators was published verbatim by ten carriers in late 1993, and by Blue Cross and Blue Shield of Minnesota in April 1994. This directive also contained the term "continuous involvement" and referenced both an "operating suite" and an "operating room." None of these carriers

defined any of the terms used in the HCFA memo apart from the context of the HCFA memo.

5. Prior to 1996, five carriers published their own versions of the July 1993 HCFA memorandum and added local variation to the text. One carrier based its guidelines for paying for personally provided services on the premise that the physician is "continuously involved" in the case with the CRNA, but did not define "continuous involvement." Three carriers changed the term "operating suite" to "operating room" and implemented a policy that the physician could not report modifier AA if he or she left the room. The fifth carrier interpreted the policy to mean that the AA modifier *was* to be used when the physician was outside the operating room but physically present in the operating suite throughout the procedure.

6. In 1996, at least three carriers indicated that their payment policy changed during that year. Blue Cross and Blue Shield of Montana stated that *prior to 1996*, payment was made at the personally provided rate when an anesthetist and an anesthesiologist were both involved in a single anesthesia service. In June, MetraHealth (Minnesota) stated that HCFA had *recently* provided clarification and indicated that failure to comply *after the date of the 1996 notice* could be considered fraud. MetraHealth (Mississippi) published a notice in August 1996 substantially similar to that published by MetraHealth (Minnesota).

Signed: Brenda Morrow Date: 2-27-97

REPORT OF JAMES F. ARENS, M.D.

I. BACKGROUND AND QUALIFICATIONS

A copy of my curriculum vitae is attached hereto and describes my background and qualifications. By way of summary, I have been an anesthesiologist since 1962. Since 1966, I have done almost exclusively cardiac and thoracic anesthesia. In 1986, I received the first certification issued in Critical Care Medicine by the American Board of Anesthesiology. Currently I am the Chief Executive Officer of UTMB Hospitals and Vice President for Clinical Affairs at The University of Texas Medical Branch (UTMB) in Galveston, Texas. From 1977 to 1990, I was Professor and Chair of the Department of Anesthesiology at UTMB and also Executive Director of the Operating Rooms at UTMB.

I am very familiar with the Medicare regulations governing anesthesiology as a result of my activities in the American Society of Anesthesiologists (ASA) which are described on my CV.

I have held various elected offices in the ASA, including serving as President from 1988-1989. Moreover, I have served on various committees including serving from 1974 to 1977 on the liaison Committee on Representation to American Association of Nurse Anesthetists. I also served from 1975 to 1980 on the Committee on Anesthesia Care Team. From 1975 to 1986 I also served on the Governmental Affairs Committee for the American Society of Anesthesiologists. While serving on the Governmental Affairs Committee, members of our committee met with HCFA representatives to discuss the ASA Guidelines that became the 1984 TEFRA regulations, now set forth at 42 C.F.R. 415.110. As a result, I know what the regulations

which reflect the ASA guidelines, were intended to require as described below. I remain involved in the ASA. Currently I am Senior Delegate from the ASA to the American Medical Association House of Delegates.

As described on my CV, I also served on numerous other committees and held other offices within the ASA. I remain familiar with the way anesthesia is practiced throughout Texas and in other areas of the country as a result of my work in the ASA and the American Medical Association.

II. BILLING MEDICARE WITH THE "AA" MODIFIER FOR A SINGLE CASE

The ASA guidelines that became the TEFRA regulations were intended to promote "good patient care", not requirements for billing. The intent of the ASA Guidelines was to implement certain requirements that would improve patient care. With regard to billing Medicare with the "AA" modifier for provision of anesthesia to a single patient, the Medicare regulations do not require the anesthesiologist to remain physically present in the operating room for the entire procedure. Moreover, the ASA Guidelines that became the TEFRA regulations were not intended to require physical presence at all times in the operating room of the anesthesiologist with the qualified anesthesia provider in a single case. That was not the standard of practice at the time the ASA Guidelines were discussed with HCFA representatives and we had no intention of changing the way anesthesia care was delivered by an anesthesia care team.

42 C.F.R. 414.45c(1)(vi) states that the anesthesiologist must be "continuously involved" in a single case. That

does not mean that the anesthesiologist must remain physically present in the operating room at all times with the qualified anesthesia provider. If the anesthesiologist is immediately available for treatment of emergencies, the anesthesiologist is "continuously involved" and does not need to be in the operating room itself.

III. ROOM VS. SUITE

An operating room is distinct from an operating suite. An operating suite includes other areas beyond the operating rooms. Although the boundaries of the operating suite may vary from hospital to hospital depending on the layout of the hospital, typically it may include all of the operating rooms, the recovery rooms, holding area, offices, break area, supply rooms, doctors' lounge, nurses' lounge, and bathrooms. The operating suite is not just the sterile areas.

An operating room, on the other hand, refers to the individual room where the surgery for a single patient takes place.

IV. EMERGENCE FROM ANESTHESIA

For purposes of 42 C.F.R. 415.110(a)(1)(iii) (which is based on the ASA Guidelines), "emergence" is defined as the process of recovering from anesthesia. It does not equate to extubation. In those cases in which a patient is intubated, extubation may occur during emergence, and may to a demanding part of the anesthesia procedure depending on the patient and the anesthesia procedure performed, but it is not itself emergence. Most patients are extubated while asleep, so they have not fully emerged at the time of extubation. A patient is considered "emerged"

from anesthesia when that patent can control his or her reflexes.

42 C.F.R. 110(a)(1)(iii) requires an anesthesiologist to "personally participate" in emergence; it does not require "presence" at emergence. The level of involvement by the anesthesiologist varies in any particular procedure depending on many factors, including the number of concurrent cases, the nature of the surgical procedure, the condition of the patient, and the skills of the qualified anesthesia provider with whom the anesthesiologist is working. Because an anesthesiologist can medically direct up to four cases at a time, the anesthesiologist may not be in the room when a patient begins to emerge. 42 C.F.R. 415.110(a)(1)(iii) does not require that the patient be kept under anesthesia until the anesthesiologist returns.

Moreover, the ASA Guidelines and the regulations derived from them (now 42 C.F.R. 415.110) were never intended to require actual physical presence in the operating room but rather immediate availability throughout the period during which emergence occurs, which is a continuum. The requirement in 42 C.F.R. 415.110(a)(1)(iii) that the anesthesiologist "participate in" emergence was intended to permit the anesthesiologist to use his or her medical judgment to determine how best to participate in emergence in one room.

An anesthesiologist can participate in emergence by checking on the patient in the recovery room and being available at other times in the emergence continuum. 42 C.F.R. 415.110(a)(1)(vii) requires provision of indicated post-anesthesia care, which is different from checking on the patient in the recovery room. When we wrote that the anesthesiologist must provide indicated post-anesthesia

care, we intended to require the anesthesiologist to provide care when emergencies or other complications occur after surgery.

V. EXCEPTION TO MEDICAL DIRECTION TO PERMIT LABOR EPIDURALS

Labor epidurals are a relatively recent phenomenon. Hospitals started offering them to obstetrical patients in the early 1970's. Labor epidurals provide safe, effective, early pain relief for women in labor and they were shown to be very useful in managing high blood pressure in pregnant patients with pre-eclampsia (pregnancy-induced hypertension). Labor epidurals made for a much more controlled environment in the labor and delivery area, and they were a much improved substitute for analgesia that was previously often provided by high doses of drugs such as Demerol and Phenergan that could result in significant respiratory depression of the newborn, which can cause cerebral palsy.

While the labor epidurals presented a medical breakthrough, anesthesiologists were often unavailable or reluctant to perform them because of the low volume of obstetrical cases in certain hospitals and because the epidurals could not by definition be scheduled. The Medicare regulation that permits the anesthesiologist to perform a labor epidural without affecting concurrency was intended to encourage anesthesiologists to perform labor epidurals when they might otherwise be reluctant to do so.

In most hospitals, the labor and delivery area is on a different floor from the operating suite for reasons of privacy and access by families. Nonetheless, the Medicare

regulations specifically permit an anesthesiologist to perform labor epidurals while medically directing cases even though the obstetrical area may be on a different floor. The fact that the labor and delivery area is on a different floor does not mean that anesthesiologists there are not immediately available to return to an operating room if needed. For the same reason, in certain situations an anesthesiologist may be able to do rounds or participate in hospital meetings and still be available to return to the operating room as needed.

VI. HANDS-OFF FROM ONE ANESTHESIOLOGIST TO ANOTHER ARE COMMON IN GROUP PRACTICE

Anesthesiologists practicing in a group practice frequently transfer responsibility for cases from one member of the group to another. Handoffs can occur at any time during the procedure. Nothing in the Medicare regulations prohibits handoffs. Based on my work with the ASA Governmental Affairs Committee that drafted what became the 1984 TEFRA regulations, I know that we did not intend to restrict when handoffs could occur.

VII. ADVICE FROM LOCAL CARRIER VS. HCFA

HCFA has told the ASA for years when we have sought national clarification of policy issues that it would not issue that clarification and instead would defer to the discretion of the local carriers. An example is monitored anesthesia care where there is a multiplicity of interpretations issued by various carriers. Thus, Medicare policies have become a patchwork of varying interpretations that depend on the local carrier. It is therefore reasonable for

anesthesiologists to rely on interpretations from the local carrier.

VIII. PUBLICATIONS

See attached Curriculum Vitae.

IX. PRIOR TESTIMONY

I have not testified at trial in the past four years. I have given a few depositions in medical malpractice cases in the last four years but do not have available the details of these cases, all of which settled or dropped as far as I know.

X. LIST OF SOURCES RELIED UPON AND/OR CONSIDERED IN FORMING OPINIONS

1. Second Amended Complaint and third amended Complaint in Qui Tam case
2. 42 C.F.R. 415.110 (Conditions for Payment: Anesthesiology Services).

XI. COMPENSATION

I am charging $350 per hour plus expenses for my services in connection with this case. To date, I have billed approximately $1,400.

Dated: December 12, 1997

/s/ James F. Arens
James F. Arens, M.D.

CURRICULUM VITAE

NAME: JAMES F. ARENS, M.D.

DATE: March 20, 1997

PRESENT POSITION AND ADDRESS:

Vice President for Clinical Affairs
Chief Executive Officer, UTMB Hospitals
Professor, Department of Anesthesiology
The University of Texas Medical Branch
Galveston, TX 77555-0138

BIOGRAPHICAL:

DATE OF BIRTH:	April 20, 1934
PLACE OF BIRTH:	Hamal, Minnesota
CITIZENSHIP:	United States
HOME ADDRESS:	22 South Shore Drive Galveston, Texas 77551

EDUCATION:

UNDERGRADUATE:	Creighton University Omaha, Nebraska 1952-1955
GRADUATE:	Creighton University Medical School Omaha, Nebraska MD, 1955-1959
POSTGRADUATE:	Rotating Internship Tripler Army Hospital Honolulu, Hawaii 1959-1960
	Anesthesiology Residency Charity Hospital New Orleans, Louisiana 1960-1962

MILITARY:

USAF – 750th Hospital
Swindon, England
Chief of Anesthesiology
1962-1965

Travis Hospital
Travis, California
Chief of Anesthesiology
1965-1966

PROFESSIONAL AND TEACHING EXPERIENCE:

1. Director of Inhalation Therapy — 1967-1972
   Ochsner Foundation Hospital
   New Orleans, Louisiana

2. Director of Intensive Care Unit — 1968-1972
   Ochsner Foundation Hospital
   New Orleans, Louisiana

3. Director, Recovery Room — 1968-1972
   and Operating Room
   Ochsner Foundation Hospital
   New Orleans, Louisiana

4. Director of Anesthesia — 1968-1972
   Ochsner Foundation Hospital
   New Orleans, Louisiana

5. Visiting Anesthesiologist — 1968-1972
   Charity Hospital
   New Orleans, Louisiana

6. Assistant Professor of Surgery — 1968-1972
   Division of Anesthesiology
   Tulane University
   New Orleans, Louisiana

7.	Medical and Administrative Director of Operating Room Ochsner Foundation Hospital New Orleans, Louisiana	1969-1972
8.	Medical Director School of Inhalation Therapy Ochsner Foundation Hospital New Orleans, Louisiana	1971-1972
9.	Director of Operating Room University of Mississippi Medical Center Jackson, Mississippi	1972-1977
10.	Professor and Chairman Department of Anesthesiology University of Mississippi Medical Center Jackson, Mississippi	1972-1977
11.	Professor Department of Pharmacology University of Mississippi Medical Center Jackson, Mississippi	1972-1977
12.	Chief of Staff University of Mississippi Medical Center Jackson, Mississippi	1974-1976
13.	Consulting Staff Mississippi Methodist Rehabilitation Center Jackson, Mississippi	1975-1977

14. Professor and Chairman — 1977-1990
Department of Anesthesiology
Rebecca Terry White Chair — 1985-1991
in Anesthesiology
The University of
Texas Medical Branch
Galveston, Texas

15. Executive Director of — 1977-1990
Operating Rooms
The University of Texas Medical Branch
Galveston, Texas

16. Acting Executive Director — 1980-1981
of Inpatient Services
The University of Texas Medical Branch
Galveston, Texas

17. Medical Director — 1981-1982
Respiratory Therapy Department
School of Allied Health Sciences
The University of Texas Medical Branch
Galveston, Texas

18. Surgical Operating and Acute — 1981-1982
Care Support Services
Associate Administrator
The University of Texas Medical Branch
Galveston, Texas

19. Medical Coordinator for — 1982-1990
Surgical Operating and
Acute Care Support Services
The University of Texas Medical Branch
Galveston, Texas

20. Vice President for Hospital Affairs — 4/90 to 8/90
ad interim
The University of Texas Medical Branch
Galveston, Texas

21. Vice President for Clinical Affairs 1990-present
The University of Texas Medical Branch
Galveston, Texas

RESEARCH ACTIVITIES:

Throughout the chairmanship at UTMB, research was fostered in the Anesthesiology Department and during the last five years as Chairman, over two million dollars a year was funded in Anesthesiology Research. Research was actively supported for Drs. Joseph Gabel, Robert Drake, Robert Wolfe, Daniel Trabor, Thomas Nelson, Eugene Flowelien, George Kramer, Sharon Nelson, J. Jeffrey Andrews and others. This commitment to research excellence provided the support and milieu in which research excellence could and did exist. A national reputation was established for Malignant Hyperpyrexia. In addition, the influence of lung water in ARDS was widely studied, especially relating to osmotic and pulmonary capillary pressures.

COMMITTEE RESPONSIBILITIES:

National:

1. Committee on Scientific Exhibits 1970-1974
American Society of Anesthesiologists

2. Chairman, Committee on Panels 1971-1972
American Society of Anesthesiologists

3. Committee on Panels American 1972-1976
Society of Anesthesiologists

4. Chairman, Committee on Scientific 1973-1974
Exhibits American Society of
Anesthesiologists

5.	Liaison Committee on Representation to American Association of Nurse Anesthetists American Society of Anesthesiologists	1974-1977
6.	Committee on Governmental Affairs American Society of Anesthesiologists	1975-1986
7.	Committee on Anesthesia Care Team American Society of Anesthesiology	1975-1990
8.	Ad Hoc Committee on Self-Evaluation American Society of Anesthesiologists	1975-1978
9.	Appeals Committee American Board of Anesthesiology	1976-1981
10.	Chairman, Committee on Reimbursement ICU Services Society of Critical Care Medicine	1977-1990
11.	Joint Council on in-Training Examinations American Board of Anesthesiology	1977-1990
12.	Task Force for Certification of Special Competence in Critical Care Medicine American Board of Medical Specialties	1978-1980
13.	In-Training Council American Society of Anesthesiologists	1978-1981
14.	Education Committee Texas Society of Anesthesiologists	1978-1990
15.	Chairman, Scientific Papers, Annual Meeting Committee American Society of Anesthesiologists	1979
16.	Ad Hoc Committee for Review of Essentials for Anesthesia Assistants	1979-1981

	Program American Society of Anesthesiologists	
17.	Vice Chairman, Annual Meeting Committee American Society of Anesthesiologists	1980
18.	Secretary, Joint Committee on Critical Care Medicine	1981
19.	Chairman, Annual Meeting Committee American Society of Anesthesiologists	1981
20.	Health Care Financing Administration Ad Hoc Committee, American Society of Anesthesiologists	1981-1984
21.	Chairman, Joint Committee on Critical Care Medicine	1982-1984
22.	In-Training Council American Society of Anesthesiologists	1983-1986
23.	Vice President, Committee on Scientific Affairs American Society of Anesthesiologists	1983-1986
24.	Executive Committee American Board of Medical Specialties	1984-1986 1994-
25.	Chairman, Committee for Critical Care Medicine Exam, American Board of Anesthesiology	1984-1987
26.	Oversight Committee for Annual Meeting American Society of Anesthesiologists	1985-1986
27.	Accreditation Council for Graduate Medical Education	1987-1993

28.	Voting Representative for The American Board of Anesthesiology to the American Board of Medical Specialties	1987-present
29.	American Society of Anesthesiologists Representative to American Medical Association Partnership on Practice Parameters	1989-present
30.	Anesthesia Patient Safety Foundation Board of Directors	1990-present
31.	Chairman, Committee on Practice Parameters American Society of Anesthesiologists	1990-present
32.	University Hospital Consortium Board of Directors	1990-present
33.	Member History Committee Texas Society of Anesthesiologists	1993-present
34.	University Hospital Consortium Executive Committee	1993-1995
35.	Member, Council for Medical Affairs American Medical Association	1994
36.	Chairman, Appeals Council American Board of Anesthesiology	1994
37.	University Hospital Consortium Chairman, Group Practice Task Force	1994
38.	Member, Outstanding Community Service Award Association of American Medical Colleges	1995
39.	Liason Council for Specialty Boards American Board of Medical Specialties	1995

UTMB

1.	Chairman, ICU Advisory Committee	1978-1990
2.	Search Committee for Selection of Chairman Department of Pharmacology	1978-1981
3.	President, Medical Service Research and Development Plan Board	1978-1980
4.	Housestaff Committee	1979-1981
5.	Search Committee for Selection of Director Shrine Burns Institute	1979-1981
6.	Chairman, Medical Records and Review Committee	1979-1981
7.	Chairperson, OR Efficiency/Utilization Committee	1984-1990
8.	Group Practice Plan	1984-1990
9.	Chairman, Search Committee for Selection of Chairman, Department of OB/Gyn	1987-1988
10.	Executive Committee, Medical Service Research and Development Plan	1987-present
11.	Member, Administrative Council	1988-present
12.	Chairman, Medical Service Research and Development Plan Board	1988-1990
13.	Steering Committee for 1991-97 UTMB Strategic Plan	1988-1990
14.	Member, University of Texas Provider Panel	1988-1990

15. Chairman, Advisory Committee for Physician Practice Plan Expenditures, UT-System — 1989-1990

16. Member, Advisory Committee for the University of Texas System Professional Medical Liability Self-Insurance Plan — 1989-present

17. Member, Committee on Peer Review and Sanctions The University of Texas System — 1989

18. Chairman, Professional Liability Review Committee — 1990-present

19. Chairman, Disaster Preparedness Committee — 1990-present

20. Member, Claims Review Committee The University of Texas System — 1990-present

21. Chairman, Managed Health Care Advisory Committee to the Texas Department of Criminal Justice — 1993-present

22. Member, MSRDP/PRS Committee The University of Texas System — 1993

23. Member, Committee on Managed Care The University of Texas System — 1993

24. Member, LBB Health Care Reform Project The State of Texas — 1994

25. Chairman, Search Committee for the Selection of Vice President for Academic Affairs and Dean of Medicine — 1994

26. Member, Committee on MSRDP Fringe Benefits The University of Texas System — 1995

27.	Member, Employee Health Insurance Provider Advisory Panel The University of Texas System	1995
28.	Vice Chairman, Governance Committee	1995-present
29.	Chairman, St. Mary's Utilization Task Force Committee The University of Texas Medical Branch	1996
30.	Member, William Temple Foundation Board Houston Diocesan Center	1997-Present

Departmental:

1.	Executive Committee	1986-1990
2.	Resident Selection Committee	1977-1990

Other:

1.	Staff Executive Committee Ochsner Foundation Hospital New Orleans, Louisiana	1968-1972
2.	Dean's V.A. Committee University of Mississippi Medical Center Jackson, Mississippi	1972-1977
3.	Executive Committee University of Mississippi Medical Center Jackson, Mississippi	1972-1977
4.	Chairman, Search Committee for Selection of Chairman Department of Psychiatry	1974

University of Mississippi Medical Center
Jackson, Mississippi

5. Chairman, Ad Hoc Committee on Continuing Education
Mississippi Society of Anesthesiology — 1974

6. Chairman, Judicial Committee
Mississippi Society of Anesthesiology — 1974-1975

7. Faculty Senate
University of Mississippi Medical Center
1974-Member
1975-President Elect
1976-President — 1974-1976

8. Promotions Committee
University of Mississippi Medical Center
Jackson, Mississippi — 1975-1977

9. Joint Conference Committee
University of Mississippi Medical Center
Jackson, Mississippi — 1975-1977

10. Consultant, Special Committee on Health System Reform
Texas Medical Association — 1993

11. Member, Ad Hoc Committee on Town Gown Issues
Texas Medical Association — 1994

MEMBERSHIP IN SCIENTIFIC SOCIETIES:

1. *Academy of Anesthesiology* (Elected)
Member — 1976-1986

2. *American Association of Inhalation Therapists*
Louisiana Chapter
Medical Director — 1972

3. *American Board of Anesthesiology*

Associate Examiner	1970-1975
Director	1975-1987
Vice President	1985-1986
President	1986-1987
Senior Examiner	1987-present

4. *American Board of Medical Specialties*

Member	1978-present
American Board of Anesthesiologists	
Voting Representative	1987
Vice President	1994
President-Elect	1995
President	1996-present

5. *American College of Anesthesiology*

Examiner	1972-1974
Board of Governors	1974-1975
Secretary	1975-1976

6. *American Council of Graduate Medical Education*

Member	1987-1993

7. *American Medical Association*

Member	1982-present
Alternate Delegate ASA	1992-1994
Voting Delegate ASA	1994-present

8. *American Registry of Respiratory Therapists*

Examiner	1970-1975

9. *American Society of Anesthesiologists* (Elected)

Member	1970-1990
Life Member	1990
Vice-President, Scientific Affairs	1983-1986

	First Vice President	1986-1987
	President-Elect	1987-1988
	President	1988-1989
	Immediate Past President	1989-1990
10.	*Association of University Anesthesiologists*	
	Member	1975-present
11.	*Faculty of Nurse Anesthesia Schools*	
	President	1975-1977
12.	*International Anesthesia Research Society*	
	Member	1972-1993
13.	*Louisiana Society of Anesthesiology*	
	Vice President	1968-1977
	President Elect	1969-1970
	President	1971-1972
14.	*Mississippi Society of Anesthesiology*	
	Member	1974-1975
15.	*Society of Academic Anesthesia Chairman*	
	Member	1975-1990
	President	1979-1980
16.	*Society of Cardiovascular Anesthesiologists*	
	Member	1979-1993
17.	*Society of Critical Care Medicine* (elected)	
	Member	1975-1993
18.	*Southern Medical Association*	
	Secretary, Section on Anesthesiology	1972
	Chairman Elect, Section on	

Anesthesiology	1973
Chairman, Section on Anesthesiology	1974

19. *Southern Society of Anesthesiology*

Vice President	1970-1971
President Elect	1971-1972
President	1972-1973

20. *Texas Medical Association*

Member	1982-present
Consultant	1993

21. *Texas Society of Anesthesiologists*

Member	1977-1990
Life Member	1990
Alternate Delegate, T.S.A.	1983-1986
Board of Directors, Ex Officio	1986-present

BOARD CERTIFICATION:

National Board of Medical Examiners (#42334)	1960
American Board of Anesthesiology (#3577)	1965
American College of Anesthesiology	1966
ABA – Critical Care Medicine (#1 Certificate)	1986
ABA – Continued Demonstration of Qualifications (#25)	1993

LICENSURE INFORMATION:

Texas E9515

HONORS:

1. Leone Award for Administrative Excellence 1984

The University of Texas
Medical Branch
Galveston, Texas

2. Bernard H. Eliesberg Lecturer — 1984
Mt. Sinai Hospital
New York, New York

3. Rebecca Terry White Chair in Anesthesiology — 1985-1991
The University of
Texas Medical Branch
Galveston, Texas

4. Establishment of James F. Arens Chair in Anesthesiology — 1986
The University of
Texas Medical Branch
Galveston, Texas

5. First Speaker at the Jerry Nudell Memorial Lecture — 1990
Cedars Sinai Medical Center
Los Angeles, California

6. Creighton University School of Medicine — 1991
Alumni Merit Award
Omaha, Nebraska

7. Establishment of The James F. Arens and Ann G. Arens Endowed Fund — 1995
The University of
Texas Medical Branch
Galveston, Texas

8. Forrest E. Leffingwell Memorial Lecture — 1996
California Society of Anesthesiologists
San Francisco, California

9. T. H. Seldon Lecture — 1997
International Anesthesia
Research Society
San Francisco, California

ADDITIONAL INFORMATION:

1. American Society of
Anesthesiologists — 1984
Representative to CMSS
Regarding DRG's

2. American Society of
Anesthesiologists Representative — 1986-1990
Health Care Financing
Administration – Harvard
Relative Value Study (Hsaio Study)

Exhibits:

1. Intermittent Cuff Inflation for Long-Term Ventilation.

   A. American Society of Anesthesiology National Meeting, San Francisco, California, October 1969.

   B. New York Society of Anesthesia, New York, New York, December 1969.

   C. American Medical Association National Meeting, Chicago, Illinois, June 1970. (Certification of Merit-Section on Anesthesiology)

   D. Midwest Anesthesiology Conference, Chicago, Illinois, May 1971.

   E. International Anesthesia Research Society National Meeting, Bal Harbor, Florida, March 1971.

2. Post-Traumatic Respiratory Insufficiency.

   A. American Society of Anesthesiology National meeting, New York, New York, November 1970. (First Place Scientific Exhibits)

   B. American College of Surgeons National Meeting, Atlantic, New Jersey, October 1971.

   C. International Anesthesia Research Society National Meeting, Las Vegas, Nevada, March 1972.

   D. Louisiana State Medical Society, New Orleans, Louisiana, May 1972. (First Place Scientific Exhibit)

3. Morphine Anesthesia for Coronary Artery Disease.

   A. American Society of Anesthesiology National Meeting, Atlanta, Georgia, October 1971.

   B. American College of Cardiology National Meeting, Chicago, Illinois, March 1972.

   C. American Medical Association National Meeting, San Francisco, California, June 1972.

   D. Association of American Medical Clinics, Atlanta, Georgia, September 1972.

   E. American College of Surgeons National Meeting, San Francisco, California, October 1972.

BIBLIOGRAPHY:

Articles in Peer-Reviewed Journals

1. *Arens, J.F.* Post-anesthetic vomiting. Am. J. Surg. 103:2-5; 1962.

2. *Arens, J.F.* Use of antagonists in drug-induced coma. JAMA 1979:752-758; 1962.

3. *Arens, J.F.* Clinical effectiveness and usefulness of topical anesthetics. Postgrad. Med. 33:269-276; 1963.

4. *Arens, J.F.* Use of angiotensin as an adjunctive agent to correct hypotensive states during anesthesia. Anesth. Analg. 42:536; 1963.

5. *Arens, J.F.* Comparative potency and effectiveness of topical anesthetics in man. Clin. Pharmacol. Ther. 5:49-62; 1964.

6. *Arens, J.F.* Cardiovascular effects of muscle relaxants. J. Am. Assoc. Nurse Anesth. 36(2):120-122; 1968.

7. *Arens, J.F.* Methoxyflurane and epinephrine administered simultaneously. Anesth. Analg. 47:530-534; 1968.

8. *Arens, J.F.* Volume limited intermittent cuff inflation for long-term respiratory assistance. J. Thorac. Cardiovas. Surg. 58:837-853; 1969.

9. *Arens, J.F.* Effect of various drugs on the course of anesthesia. J. Louisiana State Med. Soc. 122:380-382; 1970.

10. *Arens, J.F.* Carrera, A.E. Methemoglobin levels following peridural anesthesia with prilocaine for vaginal deliveries. Anesth. Analg. 92:219-222; 1970.

11. *Arens, J.F.* Epidural and caudal anesthesia for complicated obstetrics. South. Med. J. 63:44-48; 1970.

12. *Arens, J.F.* Sedation for patients on long-term ventilatory care. Inhal. Therap. 15:50-53; 1970.

13. *Arens, J.F.* Recovery Room. Topics 49: June, 1971.

14. *Arens, J.F.* Leonard, G.L. Danger of overwarming blood by microwave. JAMA 218:1045; 1971.

15. *Arens, J.F.* A hazard in the use of an Ayre's T-Piece. Anesth. Analg. 50:943-946; 1971.

16. *Arens, J.F.* Shook lung. South. Med. J. 65:206-208; 1972.

17. *Arens, J.F.* McKinnon, W.M.P. Malignant hyperpyrexia during anesthesia. JAMA 215:919-922; 1971.

18. Weber, D.R.; Benbow, B.P.; *Arens, J.F.* Pulmonary edema as a complication of increased intracranial pressure. South. Med. J. 65;1352-1355; 1972.

19. Scott, M.L.; Webre, D.R.; *Arens, J.F.*; Ochsner, J.L. Clinical application of a flow-directed balloon-tipped cardiac catheter. Am. Surg. 38:690-696, 1972.

20. *Arens, J.F.*; Banbow B.J.; Ochsner, J.L.; Theard, R.R. Morphine anesthesia for aorto-coronary bypass procedures. Anesth. Analg. 51:901-909; 1972.

21. Webre, D.R.; *Arens, J.F.* Use of cephalic and basilic veins for introduction of central venous catheters. Anesth. 38:389-392; 1973.

22. Scott, M.L.; *Arens, J.F.*; Ochsner, J.L. Fractured sternum with flail chest and post-traumatic pulmonary insufficiency syndrome. Ann. Thorac. Surg. 15:386-393; 1973.

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24. *Arens, J.F.*; LeJeune, F.E.; Webre, D.R. Maxillary sinusitis: A complication of nesotracheal intubations. Anesth. 40:415-416; 1974.

25. Barson, P.; *Arens, J.F.* Ketamine as an induction anesthetic for poor-risk patients. South. Med. J. 67:1398-1402; 1974.

26. Peuler, M.; *Arens, J.F.*; Glass, D.D. Ketamine and intraocular pressure. Anesth. 43:575-581; 1975.

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29. Malone, R.A.; McLeavey, C.A.; *Arens, J.F.* Plasma osmotic changes during major abdominal surgery. South. Med. J. 1443, 1446; 1977.

30. Gabel, J.C.; Drake, R.E.; *Arens, J.F.*; Taylor, A.E. Unchanged pulmonary capillary filtration coefficients after Escherichia Coli endotoxin infusion. J. Surg. Res. 25(2):97-104; 1978.

31. Tonnesen, A.S.; *Arens, J.F.*; Ellis, E.G.; Glass, D.D. Duration of laryngeal symptoms following intubation for mechanical ventilation. Anes. Rev. 5(11):28-31; 1978.

32. *Arens, J.F.* What's New in Anesthesiology? Texas Med.; 1979.

33. Kurusz, M.; Christmas, B.S.; *Arens, J.F.*; Tyson, K.R.T. Sodium nitroprusside as an adjunct to pediatric perfusion. J. Extracorporeal Tech. 11:189-194; 1979.

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multidisciplinary subspecialty. Crit. Care Med. 9(2):117-125; 1981.

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37. Priano, L.L.; Marrone, B.; Huber, P.; Arnold, J.A.; *Arens, J.F.* An unusual catheter complication with continuous epidural anesthesia. Anesth. Analg. 62(4):447-449; 1983.

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44. Dehring, D.J.; *Arens, J.F.* Pulmonary thromboembolism: disease recognition and patient management. Anesthesiology 73:146-164, 1990.

45. *Arens, J.F.,* The American Society of Anesthesiologists and You. Seminars in Anesthesia. 10,#3:145-152, 1990.

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47. *Arens, J.F.*, Substance Abuse: One anesthesiologist's perspective. Bulletin American College of Surgeons. 78:10-15; November 1993

48. *Arens, J.F.*, Outdated Anesthesia Equipment, Journal of Clinical Monitoring, 12:39-41, 1996

49. *Arens, J.F.*, Roizen, M.F., Pros/Con of Practice Parameters. Journal of Cardiothoracic and Vascular Anesthesia, Volume 10, Number 4 June 1996 pp538-39

Publications – Other

1. *Arens, J.F.* General principles of anesthesia. In: *Rhodes Textbook of Surgery*, Hardy, J.D. (Editor), J.B. Lippincott, Philadelphia, Pennsylvania, 1976.

2. *Arens, J.F.* Major changes on horizon for nation's health care system, Galveston Daily News, December 15, 1991.

3. *Arens, J.F.,* Health care system transformation – 1995 in *Clinical Anesthesia Updates*, Barash, Cullen

& Stoelting (Editors), Lippencott-Raven, Philadelphia, Pennsylvania, Volume 6, Number 3.

4. *Arens, J.F.,* Practice Parameters for Anesthesiology. In Health Economics and Practice Management in Anesthesia, *International Anesthesia Clinics – Fall 1995*, Macario and Lang (Editors), Little, Brown and Company, Boston, Massachusetts, Volume 33, Number 4 pp103-117.

5. *Arens, J.F.,* Pulmonary Atresia. *Essence of Anesthesia Practice*, Roizen and Fleisher (Editors), W. B. Saunders, Orlando, August 1996 p 265

6. Dehring, D.J., Coffin, S.A., *Arens, J.F.* Care of the patient with thromboembolic disorders. In *Critical Care Medicine – Perioperative Management*, Murray, Coursin, Pearl and Prough (Editors), Lippincott – Raven Press, New York, New York Chapter 48 pp 575-587

Abstracts:

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2. Tonnesen, A.S.; Cooper, J.R.; Gabel, J.C.; *Arens, J.F.*: Relationship between therapeutic intervention scoring system and mortality. Amerian Society of Anesthesiologists Annual Meeting, San Francisco, California, October, 1976.

3. Gabel, J.C.; Malone, R.A.; McLeavey, C.A.; *Arens, J.F.*: The lung safety factor and major abdominal surgery. 70th Annual Scientific Assembly of the Southern Medical Association, November, 1976.

4. Tonnesen, A.S.; Gabel, J.C.; Guidry, O.F.; Drake, R.E.; *Arens, J.F.*; Lack of effect of 100% O_2 breathing on shunt. American Society of Anesthesiologists Annual Meeting, New Orleans, Louisiana, October, 1977.

5. Tonnesen, A.S.; Glass, D.D.; Ellis, E.G.; *Arens, J.F.*; Symptoms following prolonged intubation. American Society of Anesthesiologists Annual Meeting, New Orleans, Louisiana, October, 1977.

6. Polacheck, J.W.; *Arens, J.F.*: Influence of phasic lung volume on inspiratory duration in anesthetized man. 1979.

7. Gabel, J.C.; Drake, R.E.; *Arens, J.F.*: Oxygenation as an indicator of lung fluid accumulation. American Society of Anesthesiologists Annual Meeting, Anesthesiology 51 (3): 5156; 1979.

8. *Arens, J.F.*: Pharmacology of extracorporeal circulation. American Society of Anesthesiologists Refresher Course Outline, 1980.

9. *Arens, J.F.*: Principles of extracorporeal circulation. American Society of Anesthesiology Refresher Course Outline, 1982.

10. Grant, J.A.; *Arens, J.F.*; Cooper, J.R.; Buhner, D.; Farnam, J.; Conti, V.; Guernsey, B.: Anaphylactic reactions toprotamine in insulin-dependent diabetics after cardiopulmonary bypass. Clinical Research 31(2):457A; 1983.

11. *Arens, J.F.:* Anesthesia for congenital heart disease. American Society of Anesthesiologists Refresher Course outline, 1983.

12. *Arens, J.F.:* Management of cardiopulmonary bypass. American Society of Anesthesiologists Refresher Course Outline, 1983.

13. *Arens, J.F.*: Anesthesia for adult cardiac surgery. American Society of Anesthesiologists Refresher Course Outline, 1985.

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15. Kurusz, M.; Conti, V.; *Arens, J.F.*: Survey of pump accidents. American Society of Anesthesiologists Annual Meeting, October, 1986.

16. Kurusz, M.; Conti, V.R.; *Arens, J.F.*; Brown, J.P.; Faulkner, S.C.; Manning, J.V.: Perfusion accident survey. Proceedings of American Academy of Cardiovascular Perfusion 7:57; 1986.

17. Neal, M.B.; Wallfisch, H.K.; *Arens, J.F.*: Comparison of complications from right internal jugular and left subclavian vein cannulation in a training program. American Society of Anesthesiologists Annual Meeting, Anesthesiology 67(3A):A222; 1987.

18. Samra, S.K.; Eisenberg, H.M.; *Arens, J.F.*: Effect of nitrous oxide on global and regional cerebral blood flow in humans. American Society of Anesthesiologists Meeting, San Francisco, CA – 1988. Anesthesiology 69:A-586; 1988.

19. Samra, S.K.; Turk, P.; *Arens, J.F.*: Effect of hypocapnia on regional cerebral glucose utilization. American Society of Anesthesiology Meeting, San Francisco, CA – 1988. Anesthesiology 69:A-428; 1988.

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22. *Arens, J.F.*: Extracorporeal Circulation: Past, Present, and Future. American Society of Anethesiology Refresher Course, San Antonio, Texas 1993.

23. *Arens, J.F.*: RBRVS: One Year Later. American Society of Anesthesiology Regional Refresher Course, San Antonio, Texas, 1993.

24. *Arens, J.F.*: Negotiating with Managed Care Contract Holders. American Society of Anesthesiologists Refresher Course Lecture, San Francisco, California, 1994

25. *Arens, J.F.*: Negotiating with Managed Care Contract Holders. American Society of Anesthesiologists Refresher Course Lecture, Atlanta, Georgia, 1995

26. *Arens, J.F.*: Negotiating with Managed Care Contract Holders. American Society of Anesthesiologists Refresher Course Lecture, Washington, D.C., April 1996

27. *Arens, J.F.*: Managed Care. American Society of Anesthesiologists Refresher Course Lecture, New Orleans, Louisiana, October 1996

REPORT OF BERTRAM W. COFFER, M.D.

ANESTHESIA PRACTICE DESCRIPTION

I am Bertram W. Coffer, M.D., an anesthesiologist in a group practice (now known as Critical Health Systems of North Carolina), in Raleigh, North Carolina since 1975. Currently, I am Chairman of the Board of Critical Health Systems of North Carolina and Chief of Anesthesia at Rex Hospital in Raleigh, North Carolina. I have practiced in the anesthesia care team mode since 1975. In early 1996, Raleigh Anesthesia Associates, Inc., which was our original practice, merged with Wake Anesthesia Associates to form Critical Health Systems of North Carolina. Critical Health Systems of North Carolina now employs 30 anesthesiologists and approximately 100 certified registered nurse anesthetists (CRNAs) with an administrative staff of 20-25 people including personnel responsible for billing, which we do in-house. I was President of Raleigh Anesthesia Associates, Inc. for 5 years, and am now Chairman of the Board of Critical Health Systems of North Carolina. I have been Chief of Anesthesia at Rex Hospital for the past 21 years. Other hospital related positions include memberships in the following committees: Operating Room Committee, Executive Committee, HIS Steering Committee, Chairman, Same Day Surgery Committee, Medical Practice Committee, Cardiovascular Committee, all at Rex Hospital.

Additionally, I have been Medical Director of the Same Day Surgery Center at Rex Hospital since 1986 to the present. I was on the Executive Committee of Raleigh Anesthesia Associates, Inc. from 1978 until 1996, and was President from 1992 until 1996. As my CV indicates, I have held various leadership roles in the ASA and other

medical societies. In my leadership roles, I have become knowledgeable about billing matters, including Medicare billing requirements

PROFESSIONAL ACTIVITIES

During the course of my 20 years in private practice, I have been heavily involved in the American Society of Anesthesiologists (ASA) in many ways. I was a member of the House of Delegates from 1984 until 1990 and served as president of the North Carolina Society of Anesthesiologists from 1982-83. Since 1990 I have been a member of the Board of Directors of the ASA as well as serving on numerous committees. During this tenure, I have been Chairman of the Anesthesia Care Team Committee and Chairman of the Committee on Governmental Affairs for the ASA. I also chaired a committee known as the ad hoc Committee on Medical Direction Reimbursement from 1991-94. In 1992, I was a member of the Center for Health Economics Research panel for medical direction reimbursement. A review of my curriculum vitae will show that I have been involved in these and many other activities over the last two decades. Due to the extent of my involvement, I have become quite familiar with anesthesia practices in North Carolina as well as all parts of the country. In the positions I have held, I have also become quite familiar with health care regulation and practice management issues throughout the country.

MEDICARE REGULATORY BACKGROUND OF DR. COFFER

My experience with Medicare and Medicare regulations began in the early 1980s when I was an officer in the

North Carolina Society of Anesthesiologists. My exposure became very intense in late 1982 and 1983 when I became aware that the Health Care Financing Administration (HCFA) was putting forth proposed and final regulations relating to anesthesia billing. At the time, I was President of the North Carolina Society of Anesthesiologists and became intensely involved in discussion with the American Society of Anesthesiologists, legislators, and HCFA to modify these regulations. In the course of these discussions, the issue of requirements of an anesthesiologist for medical direction arose. I was one of the early advocates that there were very specific things that anesthesiologists should do in order to qualify for Medicare reimbursement. Over the course of the next 15 years, I continued to consult with Congressional offices and professional individuals regarding HCFA regulations and their interpretation. It was my involvement and knowledge of these issues that led me to become intensely involved with my own professional organizations (the American Society of Anesthesiologists and the North Carolina Medical Society) throughout this period of time. This activity on occasion led to face to face discussions with legislators and HCFA employees on these issues.

LIST OF SOURCES RELIED UPON AND/OR CONSIDERED IN FORMING OPINIONS

- Complaint in Antitrust case and Second Amended and Third Amended Complaint in Qui Tam case
- Medicare regulations
- 7/15/93 HCFA Memorandum (C. Booth)
- Materials from North Carolina carrier

- Materials from Travelers to Minnesota anesthesiologists

- Materials from Blue Cross to Minnesota anesthesiologists

BACKGROUND AND QUALIFICATIONS

See attached Curriculum Vitae

PUBLICATIONS

None

PRIOR TESTIMONY

I was an expert witness and gave a deposition involving the death of a patient after an anesthesiologist performed a subclavian vena puncture for CVP placement. This involved a patient in eastern North Carolina and the deposition was given in the office of Robert Clay in 1996. I have offered no other court testimony or deposition in the past four years.

MEDICARE UPDATES FOR THE PRACTICING ANESTHESIOLOGIST

In my opinion and based on my experience and knowledge, the average anesthesiologist in private practice obtains information about Medicare regulation and policies from three sources: (1) his or her Medicare carrier, (2) ASA sources and mailings, and (3) the professional billing group that files claims for the anesthesiologist or his or her group. It is my opinion that most anesthesiologists

rely on their carriers' interpretations and opinions as to how they should bill for Medicare. Most anesthesiologists would regard their carriers' interpretation as the final word on Medicare regulations and policies.

"OPERATING ROOM" VERSUS "OPERATING SUITE"

In my opinion and based upon my experience and knowledge, the term "operating room" refers to a single individual operating room where a single patient's surgical procedure is performed. The term "operating suite" refers to a complex of multiple operating rooms and associated hallways, offices and other rooms in the same location within a hospital or other facility.

ANESTHESIOLOGISTS' RESPONSIBILITY/OPERATING ROOM/ANESTHESIA CARE TEAM

It is my opinion that the Medicare regulations require an anesthesiologist generally to remain in the operating suite and immediately available to any case that he or she is directing. I do not believe that the regulations require the anesthesiologist to remain in the operating room because another qualified anesthesia provider (usually a CRNA) is in the operating room with the patient. The basis for my opinions comes from numerous Medicare directives that have been provided by the carrier. My opinions also are derived from a Medicare Bulletin that was published in October of 1993 from the carrier regarding the use of "AA modifier." It is my opinion that the anesthesiologist's responsibility for remaining in the suite is no different whether he or she is directing one, two, three or four cases.

Anesthesiologists working in the anesthesia care team mode work most often with CRNAs. Anesthesiologists and CRNAs undergo substantially different training. The anesthesiologist's medical training is much longer and more in depth than the CRNA's nursing training .

MEDICARE REIMBURSEMENT REQUIREMENTS FOR ANESTHESIOLOGISTS

There are seven specific requirements that an anesthesiologist must meet in order to qualify for Medicare reimbursement in an anesthesia care team practice:

1. Perform a preanesthetic examination and evaluation;
2. Prescribe the anesthesia plan;
3. Participate in most demanding portions (including induction and emergence) of the procedure;
4. Ensure residents/nurse anesthetists are qualified;
5. Frequently monitor course of anesthesia;
6. Remain physically present and available for immediate diagnosis and emergencies; and
7. Provide indicated post-anesthesia care.

As noted above, the anesthesiologist is required to participate in the most demanding portions of the procedure, including induction and emergence from the procedure. The anesthesiologist monitors the course of the procedure, particularly procedures lasting several hours. The anesthesiologist is required to remain immediately available for any emergencies. Under the Medicare regulations, it is

permissible for an anesthesiologist in a group practice to transfer responsibility for a case to another anesthesiologist in his or her group, so long as all seven of the above-criteria are performed. Anesthesiologists must also provide post-operative care. It is the anesthesiologist who makes the final determination that the patient is stable and ready to leave the post-anesthesia care unit. In my opinion and based on my knowledge and experience, participating in emergence means that the anesthesiologist must be available and aware of the progress of the patient emerging from anesthesia. Furthermore, it is my opinion that emergence is not a specific moment in time, but rather a process that involves the elimination of the anesthetic from the patient's body as the patient gradually recovers intellectual functioning. This process usually (but not always) begins in the operating room and extends hours or days thereafter. With regard to regional anesthesia, emergence is a process that involves the elimination of the anesthetic from the patient's body but it begins as soon as the block hits its peak. The Medicare requirements regarding participation in emergence were not meant to imply that the anesthesiologist had to return to the operating room at the end of every single case. They do imply that the anesthesiologist needs to be involved in the emergence of the patient whether it be in the operating room, the recovery room, or both, depending on the circumstances.

COMPENSATION FOR EXPERT TESTIMONY/MINNESOTA CASE

I expect to receive airfare and hotel accommodations should I be asked to come to Minnesota for any trial or deposition. I do not expect to receive any compensation for testimony or deposition unless it directly takes time away from practice. If I have to testify and lose time from practice, I would expect my compensation would be no

more than $200 per hour. It should be noted that this compensation will not be received by me personally, but will revert to my practice corporation.

/s/ Bertram W. Coffer, M.D.
Bertram W. Coffer, M.D.

Dated: *12/5/92*

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BERTRAM WATTS COFFER, M.D.

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(919) 783-3034	(919) 847-3355
FAX (919) 783-9441	FAX (919) 846-1094

BORN:	May 24, 1941 Sanford, North Carolina
MARRIED:	Jeanne Elizabeth Gardner, R.N.
EDUCATION:	
1964 B.Sc.	North Carolina State University Raleigh, NC
1969 M.D.	University of North Carolina Chapel Hill, NC
1969-1971	Residency, Department of Surgery Duke University
1973-1975	Residency Department of Anesthesia North Carolina Memorial Hospital

MILITARY

1971-1973	U.S. Navy, Lt. Commander

CERTIFICATIONS:

1975	American College of Anesthesiologists
1976	American Board of Anesthesiology

MEDICAL LICENSES North Carolina, Georgia, Florida

AWARDS AND HONORS

1977-95	AMA Physician's Recognition Award for Continuing Medical Education
1992	Phi Kappa Phi, NC State University

PROFESSIONAL SOCIETY MEMBERSHIPS:

American Society of Anesthesiologists
American Medical Association
International Anesthesia Research Society
North Carolina Medical Society
Anesthesia Care Team Society
Wake County Medical Society
Raleigh Academy of Medicine
Royster Medical Society
North Carolina Society of Anesthesiologists

PRIVATE PRACTICE: RALEIGH ANESTHESIA ASSOCIATES, INC.

1975-91	Chief Executive Officer
1991-	President
1975-	Rex Hospital
1978-	Raleigh Community Hospital
1985-89	Blue Ridge Ambulatory Surgery Center

ACADEMIC POSITIONS:

1975-86	Assistant Professor of Anesthesiology University of North Carolina School of Medicine, Chapel Hill, NC

ELECTED PROFESSIONAL OFFICES:

American Society of Anesthesiologists:

1984-90	Member, House of Delegates
1986-89	Alternate Director, #27
1989-98	Director, District 27
1991-96	Board of Directors, ASA PAC
1991-94	Vice Chairman, Southern Caucus

Other:

1980-93	Executive Committee, NCSA
1980-82	Secretary-Treasurer, NCSA
1982-83	President, NCSA
1982	Secretary-Treasurer, Royster Medical Society
1982-90	Delegate, NC Medical Society
1983	Vice President, Wake County Medical Society
1983	President, Royster Medical Society
1985	President-Elect, Wake County Medical Society
1986	President, Wake County Medical Society
1988-96	Board of Directors, NC Medical Society Foundation
1989-90	Member, BCBS Anesthesiology Committee
1991	Alternate Delegate NC Medical Society
1992-93	First Vice President, NC Medical Society
1989-96	V. President, NC Medical Society Foundation
1986-96	Board of Directors, Carolina Doctors Care

1986-96	Executive Committee, Carolina Doctors Care
1985-96	Board of Directors, Health Care Savings
	MED PAC, NC Medical Society

APPOINTED POSITIONS:

American Society of Anesthesiologists:

1984-96	Member, Governmental Affairs Committee
1995-96	Chairman, Governmental Affairs Committee
1984, 86	Member, Reference Committee
1987, 89	Member, Reference Committee
1988-93	Member, Manpower Committee
1990, 92	Member, Reference Committee
1990-93	Member, Committee on Finance
1991-94	Chairman, Ad Hoc Committee on Medical Direction Reimbursement
1993-95	Chairman, Anesthesia Care Team Committee
1993-96	Committee on Scientific Affairs
1992	Member, CHER Panel for Medical Direction Reimbursement

Other:

1975-97	Operating Room Committee, Rex Hospital
1978-97	Executive Committee, Rex Hospital
1976-97	Chairman, Department of Anesthesia Rex Hospital
1976-82	Board of Directors, Wake County Blood Plan
1978-84	Consultant, NC Central Prison
1980-88	HIS Steering Committee, Rex Hospital
1983-89	Chairman, Coordinating Council of Medical Specialties, N C Medical Society

1983-89	Executive Council, N C Medical Society
1984-85	Chairman, Section on Anesthesiology, NCMS
1984-85	Member, Committee on Membership, NCMS
1985-86	Medical Director, Respiratory Care, Rex
1986-97	Chairman, Same Day Surgery Committee, Rex
1986-97	Medical Director, Same Day Surgery, Rex
1986	Medical Practice Committee
1986-93	Cardiovascular Committee
1992-93	Executive Committee, NC Medical Society
1984-96	Legislative Committee, NC Medical Society
1989-94	Finance Committee, NC Medical Society
1988-97	Executive Committee, NCMS Foundation
1989	Member, Planning Council, NC Medical Society
1993-94	Chairman Long Range Planning Committee N C Medical Society
1990-91	Chairman, Legislative Committee, Wake County Medical Society
1991-94	Aids Committee, N C Medical Society

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
FOURTH DIVISION

United States of America,
ex rel Minnesota Association
of Nurse Anesthetists,

Plaintiff,

vs.

Allina Health System Corp.,
et al.,

Defendants.

AFFIDAVIT OF KATHY PARSONS

Court File No.
4-96-734-L JGL

STATE OF MINNESOTA)
) ss.
COUNTY OF STEARNS)

I, Kathy Parsons, being first duly sworn upon oath, depose and states as follows:

1. My title is Director of Managed Care Contracting for the St. Cloud Hospital. I have held this position since 1990. Prior to that time I was a Managed Care Contract Analyst since July 1988.

2. As Director of Managed Care Contracting, I am, and at all times relevant to this action was, responsible for understanding Medicare billing and reimbursement for the St. Cloud Hospital.

3. Prior to 1989, CRNA services provided and billed to Medicare patients were reimbursed on the St. Cloud Hospital Cost Report submitted pursuant to Part A of the Medicare Program. Under Part A, the St. Cloud Hospital determined the cost of providing CRNA services to

Medicare patients, submitted those costs as part of its cost report to the medical intermediary, Blue Cross/Blue Shield of Minnesota ("BCBSM"), and received reimbursement from BCBSM as part of its overall reimbursement from Medicare for all services provided to Medicare patients at St. Cloud Hospital.

4. Beginning in 1989, Congress changed the way in which CRNA services provided to Medicare patients were billed by hospitals. Rather than the pass-through under Medicare Part A as described in Paragraph 3, CRNA services were billed directly to BCBSM under Part B. Because BCBSM had difficulties in transitioning the program from Part A to Part B, BCBSM did not begin reimbursement until after the first quarter of 1989. I had a number of phone calls with representatives of BCBSM during the early part of 1989 as the CRNA reimbursement transition occurred in an effort to comply with program billing requirements.

5. In July or August 1989, representatives from BCBSM, including Linda Mack, met at the St. Cloud Hospital with members of St. Cloud Hospital billing staff, anesthesiologists from Defendant AASC, and St. Cloud Hospital CRNAs. I participated in that meeting. In that meeting we discussed billing issues. We discussed billing for CRNA services by St. Cloud Hospital, including billing for Medicare medical necesity cases. I believe that BCBSM had an understanding of how St. Cloud Hospital billed for anesthesia services provided by St. Cloud Hospital. They did not object to how the Hospital billed for its CRNA services, including Medicare medical necessity cases.

6. Attached hereto as Exhibit A (Deposition Exhibit 1184) is a letter from Linda Mack to me dated August 28, 1989. This letter followed the meeting referred to in Paragraph 5 and a discussion I had with Ms. Mack about billing for CRNA services. I believe Ms. Mack understood how St. Cloud Hospital billed for CRNA services. She made no objection to how St. Cloud Hospital billed CRNA cases.

7. In August 1990, representatives for BCBSM again met with representatives of St. Cloud Hospital regarding the billing of CRNA services, including Mary Stotko from the Hospital billing office. St. Cloud Hospital CRNAs, and me. I recall that Linda Krecklau and one other person attended this meeting as representatives of BCBSM. At the time of that meeting in August 1990, St. Cloud Hospital was still having trouble receiving reimbursement for CRNA services. Attached hereto as Exhibit B (Bates No. SCH006370), is a follow-up correspondence to St. Cloud Hospital from BCBSM dated August 29, 1990, indicating a discussion of medical necessity cases was held (cases in the letter identified as procedure codes 00562, 00210, 00216, 00218, 00220, 00222, 00350, 00770, and 00880). In that meeting and subsequent letter, BCBSM affirmed how we were billing these medical necessity cases and, in fact, reimbursed us for cases which had been improperly denied by it dating back to the inception of Part B billing by CRNAs, January 1989.

8. St. Cloud Hospital used the modifier code "ZF" prior to late 1991 to bill for CRNA services in medical necessity cases, and has used "QX" since 1992. I did not receive any instruction from BCBSM or any other carrier, intermediary, or governmental agency indicating that these

were the incorrect modifiers to use in medical necessity cases.

FURTHER AFFIANT SAITH NOT.

/s/ Kathy Parsons
Kathy Parsons

Dated: July 30, 1998

Subscribed and sworn to before me this 30th day of July, 1998.

/s/ Tracy Hamilton Curran
Notary Public

(LOGO)
TRACY HAMILTON CURRAN
NOTARY PUBLIC –
MINNESOTA
My Comm. Exp. Jan. 31, 2000

MEDICARE

Part S Office – P.O. Box 84357 –St. Paul, Minnesota 55164 – (612) 456-8000

August 28, 1989

Kathy Parsons
St. Cloud Hospital
1406 6th Ave North
St. Cloud, MN 56303

Dear Mr. Parsons:

This is in response to our recent telephone conversation regarding reimbursement of services for both CRNA and anesthesiologist when there is a single case being performed.

According to the Medicare Carriers Manual, Section 5261 G, our instructions from the Health Care Financing Administration (HCFA) are as follows: "Where an anesthesiologist and an anesthetist are both involved in a single anesthesia service, the service is considered personally performed by the anesthesiologist. No separate payment is ordinarily recognized for the anesthetist's service. You may recognize a separate CRNA fee schedule payment only if you receive documentation showing that it is medically necessary for both the anesthesiologist and the anesthetist to be involved."

There may be certain surgical cases that require both the MDA and CRNA, some types of cases would be open heart surgery, craniotomy, spinal fusion, endarterectomy, trauma cases, etc. When a case does require more than one person to perform anesthesia, Medicare will make payment for the CRNA if medical justification is sent and it is determined by our medical staff to be reasonable.

It is our hope that HCFA will address this issue soon and arrive at some alternative to the current payment system.

If you would care to call me around the middle part of September, perhaps I will have some more information regarding this issue. I can be reached at (612) 456-8265 for any questions you may have.

Sincerely,

/s/ Linda Mack
Linda Mack
Assistant to the Medical Director
Government Program

LM:ls

MEDICARE

Part B Office – P.O. Box 64357 –St. Paul, Minnesota 55164 – (612) 456-5070 – 1-800-392-0343

August 29, 1990

Ms. Mary Stotko
Business Office
St. Cloud Hospital
1406 6th Avenue North
St. Cloud, MN 56303

Dear Ms. Stotko:

It was a pleasure meeting with you and your coworkers on August 1, 1990.

There were two issues discussed. The first was our denial of CRNA services when performed with an anesthesiologist. This involved procedure codes 00562, 00210, 00216, 00218, 00220, 00222, 00350, 00770 and 00880. As we discussed during the meeting, I requested and received a report which lists the denied claims for services between January 1, 1989, and July 30, 1990. Some of the claims had been previously adjusted and paid. The remaining claims will complete processing in the near future. I have also notified the claims department management of this problem.

The second issue was the situation with about 250 claims that are billed with only charges for time and no charge for the base units. To my knowledge, there isn't anything we can do about that situation. You would have to identify the claims, recalculate your charges, and request a review of the claims. It is quite possible that even though your charge is not as high as you feel it should be, our allowance would not be affected by a higher charge since our payment calculation includes both time and base units.

Mary, I thought I had complete [sic] the follow-up work from our meeting when I received your note and the claims that needed to be adjusted.

I have referred all the claims, except those enclosed, to Customer Service for adjustment. I am also investigating options we may have to prevent incorrectly denying these claims when we first process them. I'll keep you informed of any changes or progress.

If I may be of further assistance, please call me at (612) 456-8620.

Sincerely,

/s/ Linda Krecklau
Linda Krecklau
Professional Relations Representative

LK:cac
Enclosures

B. Anesthesiology Services

1. Procedure Codes and Modifiers

The CPT-4 procedure codes 00100-01999 are used to report anesthesia services. The following modifiers listed in the HCPCS manual must be used for anesthesia services.

AA – Physician personally performed

CJ – Two concurrent procedures, medically directed by physician

QO – Three concurrent procedures, medically directed by physician

OQ – Four concurrent procedures, medically directed by physician

AD – Medically supervised by a physician for more than four concurrent procedures

QX – CRNA with medical direction by a physician

QZ – CRNA without medical direction by a physician

NOTE: The AA modifier must be used to report the direction of residents in furnishing not more than two concurrent anesthesia services – attending physician relationship met.

Use an additional modifier for *informational purposes only* when monitored anesthesia care is given.

QS – Monitored anesthesiology care services

This modifier may be billed by a CRNA or a physician. Since this modifier is an informational modifier, it must have a pricing modifier billed with it for the services to be processed correctly.

2. General Guidelines

- The claim must show the Medicare Processing Number (MPIN) of the anesthesiologist.
- The claim must show the ICD-9 diagnosis code for services performed by anesthesiologists.
- For services performed on or after April 1, 1990, the actual time in minutes must be shown in field 24g of the HCFA-1500. The three-digit reporting system should be used.

Example:

20 Minutes	Report 020 minutes
1 hour, 33 minutes	Report 093 minutes
3 hours, 10 minutes	Report 190 minutes

[LOGO]

Blue Shield

of Minnesota

Inner Office Memo Copy To: MARY JANE SALEM. MEDICARE B DISTRIBUTION

To: BECKY TIMM

From: KATHY HENRY

Date: NOVEMBER 15, 1989

Subject: ANESTHESIOLOGIST AND ANESTHETIST INVOLVED IN SINGLE PROCEDURE

WHEN AN ANESTHESIOLOGIST AND AN ANESTHETIST ARE BOTH INVOLVED IN A SINGLE ANESTHESIA SERVICE, THE SERVICE IS CONSIDERED PERSONALLY PERFORMED BY THE ANESTHESIOLOGIST. NO SEPARATE PAYMENT IS ORDINARILY RECOGNIZED FOR THE ANESTHESIA SERVICE (SEE EXCEPTION BELOW); DENY THIS CHARGE USING ACTION CODE. KT.

WHERE AN ANESTHESIOLOGIST AND AN ANESTHETIST ARE BOTH INVOLVED IN ONE OF THE FOLLOWING PROCEDURES, THE ANESTHESIOLOGIST'S *AND* ANESTHETIST'S CHARGE MAY BOTH BE ALLOWED. THE ANESTHETIST'S CHARGE MUST BE KEYED WITH MODIFIER ZF. IF MODIFIER ZG IS SUBMITTED, CHANGE THE MODIFIER TO ZF.

CRANIOTOMY CODES – 00210, 00212, 00214, 00216, 00218, 00220 AND 00222

CAROTID ENDARTERECTOMY CODE – 00350

OPEN HEART SURGERY CODE – 00562

ABDOMINAL ANEURYSM CODES – 00770 AND 00880

MULTIPLE TRAUMA CASES –

YOU MAY RECOGNIZE A SEPARATE CRNA FEE SCHEDULE PAYMENT FOR PROCEDURES OTHER THAN THOSE LISTED ABOVE ONLY IF YOU RECEIVE DOCUMENTATION SHOWING THAT IT IS MEDICALLY NECESSARY FOR BOTH THE ANESTHESIOLOGIST AND THE ANESTHETIST TO BE INVOLVED. IF DOCUMENTATION IS ATTACHED, SEND CLAIM TO C01. THE REASONABLE CHARGE SPECIALIST (C01) WILL SEND THE CLAIM TO MEDICAL REVIEW, WHO DETERMINES IF BOTH THE CRNA/AA AND ANESTHESIOLOGIST SERVICES SHOULD BE ALLOWED IN THIS SITUATION.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS, GAYLE McKAY, LADONNA SCHWEER, JOHN OKONEK, BERNADINE OKONEK, ANNETTE ATCHISON, FRED BENJAMIN, BART BARRY, FAYE LEATHERMAN, SUE MILBACH, SANDRA HENSCHKE, JUDITH A. SCHMIDT and GARY HAGEN,

Plaintiffs,

v.

UNITY HOSPITAL, MERCY HOSPITAL, WILLIAM MACNALLY, ALLINA HEALTH SYSTEM CORP., MARK SPERRY, M.D., GARY BAGGESNTOSS, M.D., JOHN MURPHY, JAMES CUMMING, M.D., JOHN RYDBERG, M.D., MIDWEST ANESTHESIA, P.A., THELMA M. ALBAY, M.D., MINDA CASTILLEJOS, M.D., TERI HEIL, M.D., SANG HONG, M.D., TED JANOSSY, M.D., RAYMOND KLOEPPER II, M.D., JOHN MAGDSICK, M.D., THOMAS MAGGS, M.D., THOMAS POLLTA, M.D., JOHN ROSEBERG, M.D., JAI SUH, M.D., JEFFREY YUE, M.D., MARK EGGEN, M.D., METROPOLITAN ANESTHESIA NETWORK, ALLEN

Case No. 3-94-1446

TANK, THEODORE GRINDAL, ESQ., CRAIG JOHNSON, M.D., (both individually and in his capacity as President of the Minnesota Society of anesthesiologists), ST. CLOUD HOSPITAL, JOHN FROBENIUS, LINDA CHIMIELEWSKI, ANESTHESIA ASSOCIATES OF ST. CLOUD, LTD., GARY A. BOEKE, M.D., PHILIP F. BOYLE, M.D., L. MICHAEL ESPELAND, M.D., ALAN D. ESPELIEN, M.D., PAUL J. HALVERSON, M.D., LANSE C. LANG, M.D., A. WADE McMILLAN, M.D., WILLIAM H. RICE, M.D., ANNETTE E. ZWICK, M.D.,

Defendants.

Deposition of MARK SPERRY, M.D., taken before Jill Columbus, a Notary Public in and for the County of Hennepin, State of Minnesota, on Wednesday, the 15th day of May, 1996, commencing at approximately 9:45 o'clock in the morning, at 2510 Minnesota World Trade Center, 30 East Seventh Street, in the city of St. Paul, Minnesota.

* * *

[101] Travelers need to work out their differences and then once HCA and Travelers have worked out their differences of interpretation, then HCFA needs to make a decision about how to approach a problem in which one of their intermediaries has been informed to submit bills in a certain fashion and that wasn't consistent with what the HCFA home office did. And then once they've

worked out what those differences are, then I'm assuming we would be getting involved in that.

Q. All right, And you'll continue to bill the way you've been billing until somebody tells you differently?

A. . . . I'm going to continue to bill in the method that I've been advised by Travelers to bill until they advise me to submit the bill differently.

Q. Okay. Now you say you had a conversation in 1991 with somebody at Travelers?

A. Yes.

Q. Is that the first conversation that you recall about this issue with anybody at Travelers?

A. Yes.

Q. Tell me everything that he said to you and everything that you said to him as best as you recall it.

A. Well, I called up Mr. Esterley and I said that we've been advised by Mercy and Unity Hospital that there had been an audit and that audit denied charges from Mercy [102] and Unity – or that HCFA, that Travelers had denied charges from Mercy and Unity for one-to-one bills. And I described to Mr. Esterley how we practiced anesthesia. And I said that on one-to-one cases typically the hospital has CRNAs, we supervise those CRNAs and if we have one case going and there are no other concurrent cases going, how would he like me to submit those bills. Mr. Esterley told me that we should submit those bills using the AA modifier as a one-to-one case. His impression was that as long as we were not performing any other income generating service and that was our sole responsible case, we could submit that bill using the AA modifier

or as a one-to-one case. I through our conversations felt fairly comfortable that he knew that we were supervising CRNAs. I said that – I know that we discussed the issue that in our situation since the CRNAs were hospital employees it would become an awkward environment for us if I were to tell a CRNA you go sit in the lounge because this is a Medicare case and it's a one-to-one. He indicated to me that he could understand that position and that occurrence. And I suggested to him that this was a problem for us because the hospital was unhappy that they were having charges be denied. I suggested some alternatives. I said what about if we just submit all of our bills as concurrent, one-to-one. [103] That way the hospital would be getting paid for CRNA services, we would be getting reimbursed less money than if we were using the AA modifier but the net balance would be that the hospital was happy and the CRNAs were happy. As far as I was concerned and I think the rest of my group was concerned, the Travelers or the Medicare reimbursement for anesthesia services is relatively low and if it's a little bit lower it's not going to be that big of deal to us economically. He told me that if I were to submit a bill in that fashion I would be submitting a bill fraudulently because in fact my concurrency was not one-to-two, it was one-to-one. Then I also suggested the option of what about if I just don't submit a bill but I provide the anesthesia services. I won't submit a bill, the hospital then can submit their bill, there won't be an AA modifier from the anesthesiologist and the hospital would be paid for CRNA services. He told me that that would also be fraudulent because I would then be in effect in those latter two instances colluding with another medical entity so that they might receive monies and I – and that in his opinion that wasn't an appropriate action.

Q. Let me just stop you for a second. He told you that if you didn't submit bills, that that would be fraudulent because you would be colluding with the people that were [104] submitting the bills?

A. Right. I would be entering into some sort of a collusive arrangement where I would be providing a service but not billing so that another entity could bill.

Q. Okay. What else did he say?

A. I asked him if he would be willing to write me a letter. And he told me at that time that he would not be willing to write me a letter because that might be interpreted as a ruling from HCFA and he wasn't in a position to do that.

Q. So you understand that HCFA was the entity that had to provide rulings? Correct? He couldn't provide rulings?

A. Well, I think that's a mischaracterization. My understanding was that HCFA promulgated rulings, however, Travelers position was one of making an interpretation of the HCFA rules and regulations and applying them to a practical situation in which I am a party – in a practical anesthesia practice environment.

Q. By the way, you understand, do you not, that the bills that you submit to Travelers do not anywhere on them say medical direction of a single procedure? Do you understand that?

A. I believe that that might be correct. I'm not 100 percent certain

* * *

BEST AVAILABLE COPY

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Supreme Court, U.S.
FILED
AUG - 5 2002
OFFICE OF THE CLERK

No. 02-0027

In The
Supreme Court of the United States

ALLINA HEALTH SYSTEM CORP., et al.,

Petitioners,

v.

MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF FOR RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

In a situation where there is no material split in the Circuits, should this Court grant interlocutory review of a carefully considered, detailed decision of the Eighth Circuit Court of Appeals which applied existing precedents to the specific facts of this case and determined that there are material disputes of fact which preclude summary judgment and require that the matter be submitted to a jury?

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STATUTES

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STATEMENT

This is an action brought under the False Claims Act by relator, Minnesota Association of Nurse Anesthetists ("MANA"), alleging Petitioners (doctors and hospitals) knowingly submitted false claims for medical services to the United States Government. In particular, Petitioners falsely represented to Medicare that anesthesiologists performed anesthesia when they knew that those anesthesiologists were not even in the operating room when the work was actually being performed by MANA's nurse anesthetists. The hospitals were also alleged to have submitted thousands of false claims representing that two anesthesia providers had provided services during surgeries when both they and the doctors knew that only one provider was present.[1] It is further alleged that Petitioners

[1] Similar allegations have already been successfully prosecuted by the United States Government against other defendants in *United States ex rel. Poulton v. Anesthesia Associates of Burling, Inc.*, 87 F.Supp. 2d 351 (D. Vermont 2000) (in action that settled, the government alleged anesthesiologists failed to perform the services required to bill for medical direction and that routine billing for "medically directed anesthesia services where these requirements were not met constituted a violation of the False Claims Act"); *Anesthesiologists Affiliated v. Sullivan*, 941 F.2d 678 (8th Cir. 1991) (the government brought an action against anesthesiologists under the administrative False Claims Act for "knowingly" submitting 208 false Medicare claims which were for services they did not provide); *United States v. Askanazi*, 1:98-CR-130 (W.D. Mich. 1998) (November 5, 1988 Indictment ¶ 33) (anesthesiologists indicted and convicted under mail fraud statute for "billing Medicare for medically directing the provision of anesthesia services to patients by others when, in fact, at the same time he was performing surgical procedures on other patients and did not provide medical direction").

sought to conceal their fraud by altering patient medical records.[2]

On March 17, 1999, the District Court granted summary judgment and dismissed the case holding that MANA was not an "original source" and that Petitioners did not submit false claims as a matter of law. Pet. App. at 82. Respondent appealed and the Government filed an amicus brief in support of MANA's appeal taking strong exception to the District Court's decision on the merits arguing that Respondent's allegations, if true, did constitute false claims which caused the Government to overpay for the services.[3] The Eighth Circuit unanimously reversed the District Court's grant of summary judgment holding that, under well-accepted precedents, MANA is an original source, the court has subject matter jurisdiction over the action and that there are material disputed issues of fact, including the fact that MANA identified several thousand claims which were false even under Petitioners' interpretation of the regulations which precluded summary judgment. Pet. App. at 38-45.[4] Petitioners asserted no defense to these claims. Specifically, the Eighth Circuit held first that Section 3730(e)(4) did not bar the suit Pet. App. at 12-35. As an initial matter, the court agreed with Petitioners that Respondent's suit was "based upon the public disclosure" of its allegations because it was "supported by" and

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[2] The record includes the testimony of Chiefs of Surgery and medical staff at the Petitioner hospitals as well as the CRNA members of Respondent MANA who personally observed the fraud.

[3] The Government took no position on the jurisdictional issues.

[4] The Circuit affirmed the District Court's dismissal of the conspiracy count.

"similar to" the allegations that were publicly disclosed. Pet. App. at 28. In doing so, the court joined the *majority* of the Circuits though it expressly recognized that it was linguistically unnatural to reach such a conclusion in this case (since Respondent could not have derived its information from the public disclosure because it caused the public disclosure when it filed a related case). Pet. App. at 23. As a majority of the courts have done, the Eighth Circuit, however, interpreted the phrase "based upon" contextually to mean "supported by" rather than "derived from" in order to make sense of both the "public disclosure" and "original source" provisions. Pet. App. at 27.[5]

The Eighth Circuit went on to conclude that jurisdiction nevertheless exists because MANA is the "original source" of the allegations in this case. Pet. App. at 35. It held that "original sources" are not limited to natural persons, but also encompass Respondent, an association. Pet. App. at 29 n. 12 and 31-32. Drawing on the law of associational standing which allows associations in certain circumstances to stand in for their members, the court then held that Respondent had, through its members, "direct knowledge" of the pertinent information underlying the case (the actual facts making the claims false). Pet. App. at 29-33. The court rejected the assertion that Respondent had to give notice to the Government not only before it filed suit (which it did) but also before the public disclosure (which the statute nowhere requires). Pet App. 34-35.

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[5] If the Court had accepted Respondent MANA's interpretation of "based upon," it would not have needed to reach the "original source" issue since MANA would have standing to bring this action.

The Eighth Circuit next reversed the District Court's finding of no Article III standing based on no injury to the Government. Pet. App. at 35-38. The court stated that it need not decide whether (as the United States argued) a relator had standing to assert the Government's claim for penalties. Instead, the Eighth Circuit concluded that "the District Court erred in holding that the United States would have suffered no pecuniary injury even if the association proved false claims." Pet. App. at 36. The Eighth Circuit noted that Respondent's evidence, if proved at trial, demonstrates that lower Medicare payments would have been made if true claims had been filed. Pet. App. at 38.

The Eighth Circuit also reversed the District Court's conclusion that there was no triable issue on the merits of the false claims allegations. Pet. App. at 38-45. The court, noted that whether Petitioners understood the regulations was, under the circumstances given the evidence in the record, a jury question. Nevertheless, the court stressed that Respondent must prove a "knowing, not negligent, presentation of a false claim at trial." *Id.* at 40. On this factual record, the court concluded that there was sufficient evidence to warrant a trial where Petitioners' disputed claims of repeated mistakes and reliance on Government advice could be tested. Pet. App. at 38-45. Petitioners moved for reconsideration *en banc* asserting the very same arguments they now assert in their Petition to this Court. That motion was denied by the Eighth Circuit on or about March 25, 2002, as was Petitioners' later motion to stay the mandate.

ARGUMENT

Introduction

Respondent respectfully submits that none of Petitioners' arguments invite further review. The decision below was plainly correct and follows well-established doctrine of this Court and other Circuits. As Respondent will show below, Petitioners' claim of a split in the Circuits is illusory. Moreover, the Eighth Circuit's holdings regarding jurisdiction are fully consistent with this Court's previous statements on the issue and with the legislative intent of Congress. The bulk of Petitioners' arguments for review depend upon their own view of the evidence, which view ignores significant evidence to the contrary, expressly relied upon by the Eighth Circuit. Petitioners challenge the Eighth Circuit ruling on six grounds. None of Petitioners' issues presents a legal question that warrants further review by this Court. Indeed, this case is in an interlocutory posture, with the case remanded for trial, a posture that counsels against certiorari at this time. That counsel is especially strong where, as here, so much of Petitioners' challenges are arguments about disputed facts, which it is the very purpose of the trial to develop. Accordingly, we respectfully submit that this matter is unworthy of further review by this Court.

1. Original Source

a. Individual

As Petitioners' first and primary argument, they seek to challenge the Eighth Circuit's holding, based upon the factual record, that MANA is an "original source". MANA cannot be an "original source" they argue because it is not

a natural person. As the Eighth Circuit correctly determined, the interpretation offered by Petitioners has no support in the case law of *any* Circuit and directly contradicts the express intent for passage of the original source provision to promote relators of all types with direct knowledge of fraud to come forward and prosecute it. Pet. App. at 35. It is universally accepted that the 1986 amendments were passed to promote lawsuits by private citizens with knowledge to prosecute fraud against the Government and that the intent of those provisions was to find a balance which precluded "parasitic" persons who had no direct or substantive knowledge of the fraud from using "publicly disclosed" information to bring a False Claims Act action. Therefore, Congress plainly intended to encourage the original sources of those lawsuits to be able to prosecute them whether or not the Government intervened in the case. Senate Report No. 99-345 at 13-14. Petitioners' argument runs directly contrary to Congress' expressed intent. Their interpretation of the word "individual" would dramatically restrict the ability of persons with direct knowledge of fraud to recover damages on behalf of the Government. Petitioners' argument that because the word "individual" is used in the provision pertaining to original sources, that only single natural persons should be permitted to act as "original sources" would exclude associations, corporations, states, municipalities and all other entities from ever acting as an "original source" in a False Claims Act case. Contrary to the impression given by Petitioners, there is no split in the Circuits on this issue. Indeed, every Circuit which has considered the issue has agreed that entities, including corporations, *can* be original sources. *See, e.g., United States ex rel. Terminal Springfield Railway v. Quinn*, 14 F.3d 645 (D.C. Cir. 1994) (railway company was original source where its employees had indirect and undisputed

knowledge); *United States ex rel. Hartigan v. Palumbo Brothers*, 797 F.Supp. 624 (N.D. Ill. 1992) (State of Illinois was "original source"); *United States ex rel. Durcholtz and Durcholtz Excavating and Construction, Inc. v. FKW, Inc.*, 997 F.Supp. 1159 (S.D. Ind. 1998) (denying summary judgment motion finding that individual and corporation were original sources); *United States ex rel. Floyd Phillips Company v. Seivers*, 1996 WL 341563 (N.D. Ill. 1996) (company was original source); *cf. United States ex rel. S. Prawer & Co. v. Fleet*, 24 F.3d 320 (lst Cir. 1994) (qui tam action by company could proceed because it was not "parasitic" of public disclosure). *United States ex rel. Plumbers and Steamfitters Local Union No. 38 v. C.W. Roen Construction Co.*, 183 F.3d 1088 (9th Cir. 1999) (Union was original source). The Eighth Circuit properly followed the standard set forth in this Court's decision in *Clinton v. City of New York*, 524 U.S. 417, 429 (1998) in which this Court held that the word "individual" as used in a statute is properly interpreted to apply to corporations and other entities where Congress intended to permit broad access to a statute and imposing such a limitation would be plainly inconsistent with legislative intent. *See* Eighth Circuit Opinion at Pet. App. at 29 n. 12.[6]

As it did in interpreting the words "based upon," the Eighth Circuit looked to the legislative intent and context in which Congress used the word "individual." As the

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[6] This Court's holding in *Clinton* was recently followed by the Ninth Circuit in *United States v. Middleton*, 231 F.3d 1207 (9th Cir. 2000) (where the Ninth Circuit found that the word "individual" was intended to include corporations in connection with a similar federal statute to the one at issue here).

Eighth Circuit observed, it is well-accepted that the specific purpose for the adoption of the original source provision was to legislatively reverse a previous judicial decision in the case of *United States ex rel. Wisconsin v. Dean*, 729 F.2d 1100 (7th Cir. 1984), Pet. App. at 32. In that case, the State of Wisconsin was prevented from acting as a relator because it was required by law to publicly disclose to the Government information based upon its investigation of fraud in its Medicare programs. Under the earlier version of the False Claims Act, the Seventh Circuit Court held that, as a result of this disclosure, Wisconsin, even though it was the "original source" of the disclosure, could not be a relator and could not bring a False Claims Act action. In order to address this problem with the law, numerous state Attorney Generals and the United States Attorney General urged Congress to include in the 1986 amendments to the False Claims Act an "original source" provision. Senate Report No. 99-345 at 13. The specific purpose of that provision, as recognized by the Eighth Circuit and numerous other courts, including this Court, was to permit *entities* such as the State of Wisconsin who discover fraud, even if that fraud is publicly disclosed, to pursue False Claim Act actions against the wrongdoers if those entities are the "original source" of the information.[7] Thus, it is clear that Congress' specific

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[7] *United States ex rel. Stevens*, 529 U.S. 765, 120 S.Ct. 1858 (2000); *United States ex rel. Holmes v. Consumer Ins. Group*, 279 F.3d 1245, 1259 (10th Cir. 2002); *United States v. Bank of Farmington*, 166 F.3d 853 (7th Cir. 1999); *United States ex rel. Stinson v. Prudential Insurance Co.*, 944 F.2d 1149 (3d Cir. 1991). In interpreting this provision, it should be kept in mind that "in 1986 Congress responded to the Seventh Circuit's invitation [in *Wisconsin v. Dean*] by amending the Act yet another time, in order to *encourage more private enforcement suits*,

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intent was to include entities such as the State of Wisconsin and MANA as "original sources" and not to restrict entities from bringing False Claims Act actions such as the one in this case.

Petitioners' reliance on this Court's most recent decision in *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S 765 (2000) is equally misplaced and unavailing. That decision dealt with the question of whether or not a state could be a *defendant* in a False Claims Act lawsuit. The Court ruled that for numerous reasons pertaining to the legislative history of the Act and the use of the word "person" that a state could not be a defendant and, therefore, exposed to "liability" for damages. *Id.* at 787-788. The Court was not asked to address nor did it address either the "original source" requirements or any other requirements with respect to *plaintiffs* in False Claims Act actions. Nothing in this Court's decision in *Stevens* in any way supports Petitioners' proposition that Congress or this Court intended to restrict "original sources" to single natural persons. Indeed, in *Stevens*, this Court reaffirmed that the private relator's portion of the False Claims Act is constitutional.[8]

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this was done to achieve 'the golden mean' between adequate incentives for whistleblowing insiders with generally valuable information and discouragement of opportunistic plaintiffs who have no significant information to contribute on their own." Senate Rep. at 23-24 (1986) U.S.C.C.A.N. 5288-89, cited in *United States ex rel. Findley v. FPC Boron Employees Club*, 105 F.3d 675 (C.A.D.C. 1997) at 687 (emphasis supplied).

[8] The Eighth Circuit posited yet another basis for its rejection of Petitioners' argument. Under Petitioners' interpretation, the statute would permit corporations and other entities to serve as relators where there was no public disclosures and they did *not* have personal knowledge of the information but would preclude them from serving as

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Vermont Agency of Natural Resources v. United States ex rel. Stevens, 529 U.S. 765, 773-774 and 777-778 (2000).

For this reason, the Eighth Circuit was plainly correct in following this Court's decision in *Clinton v City of New York*, and holding that MANA qualifies as an original source in this case.[9] Such a conclusion comports with the familiar fact that much information gathering and reporting are organizational in nature; the "source" is often the organization as an entity, which should then bring the suit (and bear its burdens) as we have already seen in numerous cases brought by entities under the Act. This is particularly true, where as here, the fraud is widespread involving numerous defendant doctors and different hospitals.

b. Direct Knowledge

As a secondary argument, Petitioners seek review of the Eighth Circuit's determination (based upon the factual record) that MANA had direct and independent knowledge of Petitioners' fraud. As with their first issue, Petitioners cannot identify any split in the Circuits for this Court to resolve. It is undisputed that MANA's members, including MANA's Board of Directors, knew of Petitioners' fraud

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"original sources" where there was a disclosure and they did have personal knowledge of the fraud. There is nothing in the congressional record or the legislative history of the Act to explain such a seemingly arbitrary distinction. *See, e.g.,* Eighth Circuit Opinion at Pet. App. at 29 n. 12.

[9] It should be noted that Petitioners erroneously argue that the law was passed with the intention of permitting the State of Wisconsin to bring false claims only if there was no public disclosure. That is plainly not the case as can be seen from the legislative history of the Act.

because they personally observed it in the hospitals where they provided registered nurse anesthesia services. It is those nurses that provided the services which Petitioners falsely represented had been provided by the doctors. Pet. App. at 33. In addition to the knowledge of its members which the Eighth Circuit appropriately imputed to MANA, the record shows that MANA itself engaged in an independent investigation of Petitioners' fraud. This investigation included interviewing its members, hiring of attorneys to research the law, and gathering evidence (Brief of Appellant In Opposition to Appellees' Petition for Rehearing and Rehearing En Banc Tab 4 ¶ 14.) The only decisions Petitioners cite – without directly alleging a conflict, *see* Pet. 15 – involved rejections of "direct knowledge" applying the *same* legal standard to particular facts that have no counterpart here. As the Eighth Circuit explained, in both *Federal Recovery Services, Inc. v. United States,* 72 F.3d 447 (5th Cir. 1995); and *United States ex rel. Precision Co. v. Koch Indus., Inc.*, 971 F.2d 548 (10th Cir. 1992), the corporate relators were not even in existence at the time of the uncovering of the fraud and, therefore, could not possibly have contemporaneous and direct knowledge of the conduct. Pet. App. at 31.

The Eighth Circuit correctly found that direct knowledge for the associational relator existed here, drawing on established standards for associational standing to impute members' knowledge to associations. Pet. App. at 31-35.[10]

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[10] Cases in this Court have made no distinction based on whether the association was formally incorporated or not. *See, e.g., Friends of the Earth, Inc. v. Laidlaw Env. Servs., Inc.*, 528 U.S. 167 (2000); *compare with Hunt v. Washington State Apple Advertising Commission*, 432 U.S. 333, 343, 97 S.Ct. 2434 (1977); *see also Federal Electron*

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Under those standards, an association has standing when its members would have standing, "the interests at stake are germane to the organization's purposes," and individual members' participation is not needed for the relief sought. *Friends of the Earth, Inc. v. Laidlaw Env. Servs., Inc.*, 528 U.S. 167, 181 (2000). In the present context, an association like Respondent has direct knowledge of what its members know on the very subject that defines the association's purpose – here, the promotion of the practice of nurse anesthesia.[11] Just as the relators in *Springfield Railway* and *United States ex rel. Stinson, Lyons, Gerlin & Bustamante, P.A. v. Provident Life & Acc. Ins. Co.*, 721 F.Supp. 1247 (S.D. Fla. 1989), were allowed to pursue their claims, Respondent MANA, has the right to rely both upon the fruits of its own investigation, as well as the

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Comm'n v. Massachusetts Citizens for Life, Inc., 474 U.S. 238, 263-264, 107 S.Ct. 616 (1986).

[11] The Eighth Circuit's ruling, borrowing from associational standing law, plainly would not encompass Petitioners' hypothetical about the Sierra Club being attributed knowledge of its nurse anesthetist members on anesthesia billing practices. Petitioners posit a hypothetical slippery slope argument concerning the Sierra Club. The argument is inapposite because MANA's express purpose was to promote the practice of anesthesia and to support nurse anesthetists to provide anesthesia in hospitals. (Pet. App. at 15) Thus, the purpose of the organization was directly related to the information being gathered by its members concerning the practice of anesthesia in Minnesota hospitals which the Eighth Circuit imputed to MANA. In contrast, the Sierra Club has no relationship to the provision of anesthesia nor are its members required to be Certified Registered Nurse Anesthetists. Furthermore, as noted as the Eighth Circuit found, the record demonstrates that MANA also conducted its own independent investigation and, thereby, obtained its own knowledge of the fraud in question.

knowledge of its members, to prosecute Petitioners' fraud.[12]

c. Pre-suit Disclosure

As a third argument, Petitioners also ask this Court to write additional requirements into the False Claims Act which would restrict prosecution of fraud. Petitioners ask this Court to hold that original sources are required to voluntarily disclose information concerning the fraud to the Government before the public disclosure occurs instead of before they file suit as the statute states. We respectfully submit that the Eighth Circuit correctly declined to rewrite the statute in this manner. Petitioners do not dispute the Eighth Circuit's statement that such a requirement "has no textual basis in the statute" (Pet. App. at 34) or the court's explanation that imposition of an additional requirement would alter the "balance" struck by Congress. Pet. App. at 35. Instead, Petitioners rely on two decisions discussing pre-disclosure notice. However, the statements in those decisions do *not* create a conflict in governing law warranting review. In *United States ex rel. Findley v. FPC Boron Employees' Club*, 105 F.3d 675 (D.C.

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[12] Contrary to Petitioners' representation, there was dispute below as to the corporate status of MANA. It was Petitioners' counsel that advised the Court at oral argument that MANA was an unincorporated association (see oral argument at 40 minutes 58 seconds, available at the Court's web site). In fact, as was developed in connection with Petitioners' motions for reconsideration *en banc*, the factual record was unclear on this point. Nevertheless, for the reasons expressed herein, whether or not MANA was an incorporated association or simply an unincorporated association at the time the Complaint was filed makes no difference under the facts at issue as was recognized by the Eighth Circuit when it denied Petitioners' motion for rehearing on this issue.

Cir. 1997), the statement concerning disclosure was *dictum*, because the express reason given for disqualifying the relator as an original source was *not* late notice, but rather his lack of knowledge of the information until after public disclosure. 105 F.3d at 690. In *United States ex rel. McKenzie v. Bell South Telecom, Inc.*, 123 F.3d 935 (6th Cir. 1997), the Court critically emphasized the fact that the relator was not even the source of the public disclosure, which had been made by third parties independently stating: "Anyone who alerts the Government and is a 'true whistleblower' deserves any reward that may be obtained by pursuing a qui tam action under the FCA. However, the individual who sits on the sidelines while others disclose the allegations that form the basis of her complaint should not be able to participate in any award." *Id.* at 943. Both decisions made an overtly non-textual judgment on the facts before them that a "parasitic" relator who did not perform the contemplated role of bringing the relevant information to light should not be able to take advantage of the Act's provisions.

Unless and until the *Findley* and *McKenzie* Circuits expand their rulings to cover the present situation, there is no conflict in the Circuits which warrants review. Because a blanket pre-disclosure notice requirement is so clearly unfounded in the text, and would not be justified under the more general policy terms invoked in this case, there is no good reason to assume that those Circuits would adopt a blanket rule. Meanwhile, otherwise-qualifying relators presumably can simply adjust the timing of their Government disclosures. It would be distinctly unjust to oust (or further delay trial on) a suit like this one (filed in 1994) on the basis of such a nontextual requirement that, had it been expressed, could easily

have been satisfied by Respondent. Furthermore, there is nothing in the legislative history or the wording of the False Claims Act which would suggest that Congress would have wished that relators such as MANA, who are the only original source of the information, should be precluded from prosecuting fraud merely because they were forced to publicly disclose it before they had an opportunity to disclose their information to the Government.[13] Such a holding would be inconsistent with Congress' intent as expressed in the statute to "reward persons who discovered and revealed fraud rather than confiscating their claims." Pet. App. at 35. In fact, the legislative history directly contradicts such a conclusion. Senator Grassley, the main sponsor of the 1986 amendment, specifically stated that the sole purpose of the "voluntary disclosure" requirement was to prevent relators whose disclosures to the Government had been involuntarily compelled by "subpoenas" to then achieve a windfall by filing a False Claims Act action. As the Senator explained, the purpose of the use of the word "voluntary" was to avoid such an incongruous result.[14] Cong. Rec. S11238-04. The

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[13] Since under the False Claims Act, complaints must be filed under seal for 60 days, Respondent was precluded from seeking relief from the Court on an emergent basis by way of a False Claims Act complaint. *See* 31 U.S.C. § 3730.

[14] Petitioners' reliance on a fragment of a statement made by one of the members of the House of Representatives is misplaced and misguided. There is no way to make sense out of this statement since it implies that disclosure of the false claims information to the *news media* would *not* constitute public disclosure but *would* satisfy the requirement of disclosure to the government. No court has ever interpreted the original source requirement to so provide and there is nothing in the text of the provision itself to support such an interpretation.

undisputed facts in this case are that MANA voluntarily disclosed its information concerning the fraud to the Government and was never under a subpoena or investigation prior to doing so. *See, e.g. United States ex rel. Precision Company v. Koch Industries*, 1995 WL 812134 Slip Op. at 10 (N.D. Okla.)[15] Accordingly, for the foregoing reasons, there is no purpose for interlocutory review of the Eighth Circuit's ruling on this issue.

2. Other Issues

Petitioners present several other attacks on the Eighth Circuit ruling. Pet. 18-19. These fact-specific challenges present no legal issue. Instead, they make pleas against liability based on misreadings of the Eighth Circuit's opinion or objections to its holding that the record in this case creates a triable issue on critical fact questions. None of these challenges merits review.

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[15] Petitioners inaccurately state that the record shows that the only information supplied to the Government were facts in the public record. As the Eighth Circuit acknowledged and as was further explicated in oral argument, the Department of Justice was fully informed of the identity of witnesses, documents and other information at the time of filing of the complaint by MANA's counsel. Pet. App. 34. MANA's counsel was told to retain the documents and to await further instructions at that time and many of those witnesses and documents were later reviewed by the Government in depth as was testified to at length. (See oral argument between minutes 13 and 14, available at the Court's web site.) Significantly, the Government has never at any time during this process maintained that it did not receive full and complete cooperation from MANA and its members. Indeed, the Government filed an amicus brief in support of MANA's appeal which brief specifically stated that the Government had "authorized MANA to proceed with its False Claims Act action." *See* Amicus Brief at p.13.

a. Injury

As noted by the Eighth Circuit, Petitioners' argument that MANA lacks standing against the hospitals because it cannot establish injury is without merit. As a preliminary matter, the False Claims Act clearly provides for recovery against defendants who submit false claims whether or not those false claims are ever paid. This Court, seven Circuits and twenty-seven courts overall have so held.[16]

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[16] *See, e.g.*, United States Supreme Court: *United States ex rel. Marcus v. Hess*, 317 U.S. 537, 549-552 (1943); Second Circuit: District Court: *Blusal Meats, Inc. v. United States*, 638 F.Supp. 824, 827 (S.D.N.Y. 1986); *United States v. Rapoport*, 514 F.Supp. 519, 524 (S.D.N.Y. 1981); *United States v. Silver*, 384 F.Supp. 617, 620 (E.D.N.Y. 1974), *aff'd mem.*, 515 F.2d 505 (2d Cir. 1975); Third Circuit: *United States v. Tieger*, 234 F.2d 589, 590 & n.4 (3d Cir.), *cert. denied*, 352 U.S. 941 (1956); *United States v. Rohleder*, 157 F.2d 126, 129 (3d Cir. 1946); District Court: *United States v. Kensington Hospital*, 760 F.Supp. 1120, 1227 (E.D. Pa. 1991); *United States v. Zulli*, 418 F.Supp. 252, 253 (E.D. Pa. 1975); *United States v. American Precision Products Corp.*, 115 F.Supp. 823, 827-828 (D.N.J. 1953); Fourth Circuit: *Tbepleman v. United States*, 263 F.2d 697, 699 (4th Cir.), *cert. denied sub nom, Cato v. United States*, 359 U.S. 989 (1959); District Court: *United States v. CFW Construction Co.*, 649 F.Supp. 616, 618 (D.S.C. 1986); Fifth Circuit: *United States ex rel. Weinberger v. Equifax, Inc.*, 557 F.2d 456, 460-461 (5th Cir. 1977), *cert. denied*, 434 U.S. 1035 (1978); *United States v. Rigdela State Bank*, 357 F.2d 495, 497 (5th Cir. 1966); District Court: *Thevenot v. National Food Insurance Program*, 620 F.Supp. 391, 396 (W.D. La. 1985); Sixth Circuit: District Court: *United States ex rel. Pogue v. American Healthcorp., Inc.*, 914 F.Supp. 1507, 1509 (M.D. Tenn. 1996); *Wilkins ex rel. United States v. State of Ohio*, 885 F.Supp. 1055, 1060 (S.D. Ohio 1995); Seventh Circuit: *United States v. Hughes*, 585 F.2d 284, 286 n.1 (7th Cir. 1978); *United States v. First National Bank of Cicero*, 957 F.2d 1362, 1373 n.11 (7th Cir. 1992); District Court: *United States ex rel. Fahner v. Alaska*, 591 F.Supp. 794, 798 (N.D. Ill. 1984); *United States ex rel. Fallon v. Accudyne Corp.*, 921 F.Supp. 611, 628 (W.D. Wis. 1995); Ninth Circuit: *United States ex rel. Hagood v. Sanoma County Water Agency*, 929 F.2d 1416, 1421 (9th Cir. 1991); Tenth Circuit: *Fleming v. United States*, 336 F.2d 475, 480 (10th Cir.

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More importantly, the Eighth Circuit did not even *reach* this issue. Instead, it held, relying on the amicus brief submitted by the United States Government, that the hospitals *did* cause damage to the Government. Pet. App. at 38. Amicus Brief pp. 17-18. For example, hospitals certified in thousands of bills that it was medically necessary for two providers to provide anesthesia to patients in difficult cases such as heart transplants, brain surgery, etc., when they knew that only one provider was providing those services. As a result of these false bills, Medicare actually paid "double" the cost of the procedure. Pet App. 38; United States Amicus Brief at 17-18. Thus, the hospitals did substantially damage the United States Government. Based upon the foregoing, no further review of the Eighth Circuit's decision is necessary at this time.

b. Falsity and Government Advice

As one of their subsidiary arguments, Petitioners claim that with respect to a certain portion of the alleged false claims, they believed they were obeying the rules and that they were following Government advice. These are fact-specific arguments which go to state of mind and credibility which must be made to a jury as the Eighth

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1964), *cert. denied*, 380 U.S. 907 (1965); District Court: *United States v. Johnston*, 138 F.Supp. 525, 527-28 (W.D. Okla. 1956); Eleventh Circuit: *United States v. Killough*, 848 F.2d 1523, 1533 (11th Cir. 1988); District Court: *United States ex rel. Luther v. Consolidated Industries, Inc.*, 720 F.Supp. 919, 923 (N.D. Ala. 1989); *United States ex rel. Stinson v. Provident Life & Accident Ins. Co.*, 721 F.Supp. 1247, 1258-59 (S.D. Fla. 1989), citing *Blusal Meats, Inc. v. United States*, 638 F.Supp. 824, 827 (S.D.N.Y. 1986); Court of Claims: *Brown v. United States*, 524 F.2d 693, 706 (Ct. Cl. 1975).

Circuit recognized. Pet. App. at 39-40. The Eighth Circuit further pointed out that defendants would not be liable for false claims unless Respondent proves "knowing, not negligent, presentation of a false claim at trial." Petitioners' claim of undisputed government advice is fact-specific and misconstrues the record. The portions of the record presented to this Court by Petitioners is incomplete in several material respects. Rather than being undisputed, Petitioners' conclusions in this regard are hotly disputed by Government officials and, as the Eighth Circuit acknowledged, there is extensive evidence in the record to suggest that the Petitioners knew very well that they were violating the rules and that their actions were contrary to the interpretations imposed by the Health Care Finance Administration. In particular, the record demonstrates that one of the Medicare intermediaries in Minnesota, Blue Cross Blue Shield, issued both a letter in 1987 and a bulletin in 1988 which was sent directly to several of the Petitioners and was widely circulated and available to other Petitioners which was written by a high-ranking HCFA official. That letter states that the anesthesiologist who wants to work with a CRNA must be "continuously present with the CRNA throughout the case" to bill for "personal performance." *See* Appendix for Appellant A-609. MANA also presented evidence of proposed rules and comments published in the federal register which clearly placed the Petitioners on notice that they could not leave the room for substantial periods of time and bill for personally performing cases. Appendix for Appellant A-575. MANA also presented affidavits from Medicare that MANA's interpretation of the rules was correct (Pet. App. at 239-241) as well as letters and testimony from James Menas and Charles Booth, the HCFA officials responsible for interpreting the rules, who confirmed that Respondent's interpretation is correct. Respondent's Brief In

Opposition To Rehearing, Tab 3 p. 80-81, 86. More importantly, Petitioners claim that they could leave the operating room and travel throughout the hospital while billing for "personally performing" cases defies common sense. This is particularly true because it is undisputed that the CRNAs who remained in the room sometimes for up to six or seven hours and directly provided the anesthesia to the patients receive no payment from Medicare where the anesthesiologist billed for personally performing the case. Thus, Petitioners' claim is that they honestly believed that the government passed a regulation which allowed them to leave their patient and bill the same amount as if they had directly provided all anesthesia services during surgery to the patient. At the same time, the government would not reimburse the CRNA who actually provided those services in the operating room one penny. As the Eighth Circuit correctly determined, Respondent should have a right to test this dubious claim concerning Petitioners' subjective intent before a jury.

Petitioners attack the Eighth Circuit's decision claiming once again a split in the Circuits. However, such split is illusory. Petitioners cite no conflicting authority and no other Circuit precedent which is inconsistent with the Eighth Circuit's holding. The Petitioners cite only two decisions to support their argument – one of which (*United States ex rel. Oliver v. Parsons Co.,* 195 F.3d 457, 463 (9th Cir. 1999)) expressly *endorses* the principle underlying the Eighth Circuit's holding. The Eighth Circuit opinion merely reasons that where, as in this case, there is evidence that a regulation has been enforced and interpreted to prohibit conduct by the agency responsible, a jury trial is appropriate to determine whether defendants' conduct was "knowing" under the False Claims Act or was merely a mistake based on "good faith" as defendants claim. The contrary position urged by Respondent would render the

regulations unenforceable because, as the Government points out, a clever defendant's counsel could easily conjure up post facto interpretations of the regulation which would excuse the defendant's conduct. Pet. App. at 38-39; United States Amicus Brief at pp. 24-26. Furthermore, contrary to Petitioners' Respondent's claim, there is no dispute as to how HCFA interpreted the meaning of the regulations. (See n.17 *infra*), Pet App. 11, 40, 42. The Eighth Circuit relied on this evidence, which was ignored by Petitioners and the District Court to conclude a dispute of fact exists. The court considered Petitioners' disputed claims (1) that a Travelers functionary advised them that they did not have to stay in the operating room with their patients the whole time; and (2) that HCFA issued a 1993 bulletin which defendants believed supported this position.[17] The Eighth Circuit correctly determined that Petitioners claimed reliance upon the 1993 HCFA bulletin in question was a jury question. The court observed that the bulletin was quickly clarified within a matter of months by a representative of HCFA who clearly explained that the Petitioners could "not leave the room" in a personally performed case. Pet. App. at 42. As that letter

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[17] Petitioners neglected to advise this Court that the letter written by Travelers was written only to an in-house lawyer for Petitioner Allina who admitted in his deposition that he *did not rely* on the letter because he knew that the information was incorrect because he had been told otherwise by "investigative officials" and had reviewed carrier bulletins which he concluded clearly required anesthesiologists to stay in the room in "personal performance" cases. Respondent's Brief In Opposition To Rehearing, tab 3, p. 69. That attorney further advised that he did not disclose the letter to any of the other Petitioners in this case and, accordingly, they could not have relied upon it. *Id.* at 67; Appellants' Appendix at 2482, 2485.

pointed out, "technically there would be nobody for the doctor to hand the case off to" because the CRNA involved in the case was not being paid and not considered by HCFA to be performing the case. Pet. App. at 42-43. Thus, any ambiguity which allegedly existed was quickly rectified. Nevertheless, the Petitioners continued to bill improperly for a significant period of time thereafter until they were directly ordered to stop by the Government. As set forth in Pet. App. at 38-45, *Covington v. Sisters of the Third Order of St. Dominicks of Harford, California*, 61 F.3d 909 (9th Cir. 1993); and *Anesthesiologists Affiliated v. Sullivan*, 941 F.2d 678 (8th Cir. 1991), courts have observed that whether or not hospitals or doctors did all they could to comply with the regulations, even where it is alleged that agents of the Government supplied incorrect advice, is at best a factual issue which must be decided by a jury taking all of the evidence in the record into account, including the Petitioners' credibility. Additionally, the Eighth Circuit correctly noted that there was substantial evidence in the record that Petitioners *knew* they were fraudulently billing and were attempting to *conceal* their fraud from the Government. Pet. App. at 45. This evidence included testimony that Petitioners intentionally altered times, numbers and other information on patient medical records and threatened CRNAs who attempted to document their conduct. One of the Petitioners openly admitted that he knew they were falsely billing. Pet. App. at 44-45. A Unity/Mercy Hospital doctor observed that attending meetings and leaving the operating room while billing for personally performing cases was "not right" and they

would eventually "get caught" (Brief in Opposition to Rehearing and Rehearing En Banc Appendix p. 48).[18]

Finally, Petitioners' claim, that HCFA's interpretation that the personal performance statute required them to remain in the room is central to this case, is itself incorrect. The record examined by the Eighth Circuit supports a jury finding that Petitioners established a custom and practice which failed to satisfy even the most minimum requirements for anesthesia reimbursement because they failed to participate in emergence, failed to be present at demanding parts of the anesthesia plan, and failed to remain continuously involved in personally performed cases. Pet. App. at 44-46. In many cases they never even entered the operating room. Pet App. 43-45. Based upon this extensive evidence, the Eighth Circuit correctly determined that there are material disputes of fact which require a jury to decide this issue. For these reasons review should be denied.

(c) Petitioners' final argument which pertains to the "emergence" requirement is not worthy of further review because it is heavily fact-laden. As the Eighth Circuit correctly determined, there is substantial evidence in the record that HCFA, MANA's members and the doctors

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[18] In addition, as the Eighth Circuit noted, MANA presented extensive evidence in the record that defendants submitted false claims that would not justify reimbursement under even their own nonsensical interpretation of the rules. Pet. App. at 44-45. For example, they billed for "personal performance" of anesthesia when they were actually providing and billing for anesthesia in other operating rooms at the same time. In fact, as the Government recognized in its amicus brief, MANA identified numerous claims submitted by Petitioners to which Petitioners asserted no legal defense at all. United States Government Amicus Brief at p. 18.

clearly understood that personal participation in emergence required, at a minimum, being present in the operating room at the end of the surgery. Pet. App. at 46-47. Petitioners' claims in depositions that they believed that they could satisfy this requirement by visiting the patient, or calling him on the telephone three days later are patently absurd.[19] The foregoing demonstrates that this is an issue of fact for the jury and certainly is not worthy of further review by this highest Court.

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[19] Contrary to Petitioners' representation, MANA presented substantial medical evidence concerning the meaning of the term "emergence", including testimony of the very HCFA official who drafted the regulations, excerpts from a well-accepted treatise on anesthesiology, and the testimony of numerous CRNAs, including MANA's billing expert who participated in the drafting of the original provisions which would support a finding that Petitioners' interpretation of the statute pertaining to "emergence" is plainly wrong. Pet. App. at 46-47. The Eighth Circuit recognized the District Court could not ignore this evidence which created a material disputed fact on this issue. Pet. App. at 47.

CONCLUSION

Petitioners' Petition raises no new significant or important issues. The Eighth Circuit's well-considered opinion is fully consistent with existing precedent as well as decisions of this Court. For the foregoing reasons, review by this Court is both unnecessary and unwarranted. The Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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No. 02-27

IN THE
Supreme Court of the United States

ALLINA HEALTH SYSTEM CORP., *et al.*,
Petitioners,

v.

UNITED STATES OF AMERICA, EX REL. MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE FOR THE AMERICAN HOSPITAL ASSOCIATION, THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, AND THE MINNESOTA HOSPITAL AND HEALTHCARE PARTNERSHIP IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE

Pursuant to Supreme Court Rule 37.2, the American Hospital Association (AHA), the Catholic Health Association of the United States (CHA), and the Minnesota Hospital and Healthcare Partnership (MHHP) move for leave to file the attached brief amici curiae in support of the petition. Petitioners have consented to the filing of this brief. Respondent has not consented, necessitating this motion.

AHA is the national advocacy organization for hospitals in this country. It represents approximately 5,000 hospitals, health systems, networks, and other care providers. AHA's mission is to promote high-quality health care and health

services through leadership and assistance to hospitals in meeting the health care needs of their communities.

The Catholic Health Association of the United States (CHA) is the national leadership organization representing the Catholic health ministry. CHA's more than 2,000 members form the nation's largest group of not-for-profit Catholic health care systems, sponsors, facilities, health plans, and related organizations. Catholic health care systems and facilities are present in all 50 states and are active in developing integrated networks and partnerships across the full continuum of health care.

The Minnesota Hospital and Healthcare Partnership (MHHP) is a non-profit, statewide advocacy organization representing all of Minnesota's 140 non-profit, community-based hospitals and 19 health systems. MHHP is committed to helping its members provide affordable access to quality health care for all Minnesotans. As an association, MHHP provides valuable compliance training programs for hospitals and health systems, seeks regulatory reforms, and strives to improve patient safety efforts, emergency preparedness planning and work force environments for hospitals to meet the needs of their communities.

Amici's members deliver health care services to millions of Americans. The federal government reimburses providers for many of those services in whole or in part through Medicare, Medicaid, CHAMPUS, and other federal health care programs.

One way in which amici promote the interests of their members is by participating as amicus curiae in cases where the outcome will have important and far-ranging consequences for their members. *See, e.g.*, *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000) (AHA amicus brief); *Vermont Agency of Natural Res.* v. *United States ex rel. Stevens*, 529 U.S. 765 (2000) (same); *Washington* v. *Glucksberg*, 521 U.S. 702 (1997) (CHA amicus brief).

This is such a case. As participants in the Medicare program, amici's members must comply with the program's complex regulatory standards governing reimbursement of provider claims. Their members are also subjected to qui tam lawsuits brought by private citizens under the False Claims Act, a powerful enforcement statute that, among other things, provides for penalties of up to $11,000 for *each* "false claim" submitted to the Government. The Eighth Circuit concluded that the hospital petitioners "were on notice of the possibility" that their interpretation of governing regulations was subject to question, reversed a District Court's grant of summary judgment for the petitioners, and remanded for a trial on the relator's claims. Following the Eighth Circuit's opinion, False Claims Act relators can survive summary judgment simply by pointing to another reasonable interpretation of the regulation in question. That standard conflicts with the standard articulated by several other courts of appeal.

Amici are uniquely situated to assess the practical implications of the Eighth Circuit's ruling and the need for resolution of the conflict the decision creates. In particular, amici will highlight for the Court the magnitude and complexity of the Medicare regulations forming the basis for this and other False Claims Act lawsuits, and the grave problems posed by the Eighth Circuit's overly lenient standard for sending False Claims Act suits to the jury.

Accordingly, AHA, CHA, and MHHP respectfully request that the Court grant this motion for leave to file the attached brief amici curiae.

Respectfully submitted,

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BRIEF FOR AMICI CURIAE AMERICAN HOSPITAL ASSOCIATION, THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, AND THE MINNESOTA HOSPITAL AND HEALTHCARE PARTNERSHIP IN SUPPORT OF PETITIONERS

STATEMENT OF INTEREST OF AMICI CURIAE[1]

Founded in 1898, amicus American Hospital Association (AHA), is the national advocacy organization for hospitals in this country. It represents approximately 5,000 hospitals,

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[1] No counsel for any party authored this brief in whole or in part, and no person or entity, other than the amici curiae and their members, made a monetary contribution to the preparation or submission of this brief. S. Ct. Rule 37.6.

health systems, networks, and other care providers. AHA leads, represents, and serves health care provider organizations that are committed to health care improvement. Amicus Catholic Health Association of the United States (CHA), founded in 1915, is the national leadership organization representing the Catholic health ministry. CHA's more than 2,000 members, present in all 50 states, form the nation's largest group of not-for-profit Catholic health care systems, sponsors, facilities, health plans, and related organizations. Amicus Minnesota Hospital and Healthcare Partnership (MHHP) is a non-profit, statewide advocacy organization representing all of Minnesota's 140 non-profit, community-based hospitals and 19 health systems. MHHP is committed to helping its members provide affordable access to quality health care for all Minnesotans.

The questions presented in this petition have tremendous practical importance to amici's members, many of whom are subjected to litigation initiated by private citizens under the False Claims Act. AHA has a strong commitment to ensuring that hospitals have the information and tools they need to comply with the vast array of federal and state laws and regulations governing Medicare and Medicaid reimbursement issues. AHA and CHA regularly provide updates to their members on guidance issued by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA).[2] AHA also has instituted a formal process with CMS to obtain additional guidance on complex regulatory interpretation issues that regularly arise when attempting to translate guidance into compliance. CHA likewise regularly engages CMS to clarify reimbursement rules and regulations, and recently facilitated the submission by its members of extensive comments to the

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[2] HCFA was renamed the Centers for Medicare and Medicaid Services on July 1, 2001. *See* http://cms.hhs.gov/about/reorg.asp (last modified Mar. 6, 2002).

Department of Health and Human Services addressing issues relating to burdensome reimbursement regulations.

The Eighth Circuit's opinion subjects False Claims Act defendants to jury trials whenever it can be shown that those defendants were "on notice" of other interpretations of governing regulations—even if the defendants' interpretation was reasonable, and even if, as in this case, defendants sought guidance from the Government on the proper interpretation of complex or ambiguous regulations. The Eighth Circuit's decision conflicts with the decisions of several other courts of appeal. And if it remains in place, the decision will threaten amici's members with substantially increased exposure to frivolous False Claims Act lawsuits, diverting precious resources away from patient care.

STATEMENT OF THE CASE

"Medicare and Medicaid regulations are among the most complicated and confusing regulatory schemes in the United States." Timothy P. Blanchard, American Health Lawyers Ass'n, *Medicare and Medicaid False Claims: Legal Complexities and Developing Issues* 41 (1996). Medicare is a "massive" and "complex" regulatory program, "embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations." *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000). Providers are governed by over 132,000 pages of laws, rules, and regulations—three times the size of the Internal Revenue Code and regulations. *See Mayo Chronicles Medicare Regs: It's 132,720 Pages of Red Tape*, Mod. Healthcare, Mar. 15, 1999, at 64 (describing page by page inventory of Medicare regulations); *Rx for the Health Care System,* Wall St. J., Oct 8, 1998, at A18.

This Court and the lower courts have often recognized that the Medicare statute and regulations are texts of practically inscrutable complexity—even by Congress's standards. *See, e.g., Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981)

("The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction, as Judge Friendly has observed, makes the Act 'almost unintelligible to the uninitiated.' ") (quoting *Friedman* v. *Berger*, 547 F.2d 724, 727 n.7 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977)); *Rehabilitation Ass'n of Va., Inc.* v. *Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994) (Medicare statutes and regulations "are among the most completely impenetrable texts within human experience"), *cert. denied*, 516 U.S. 811 (1995).

Hospitals and health systems constantly must navigate this "morass of bureaucratic complexity," *Herweg* v. *Ray*, 455 U.S. 265, 279 (1982) (Burger, C.J., dissenting), submitting, on average, nearly 200,000 Medicare claims a day. *See Medicare Enforcement Actions: The Federal Government's Anti-Fraud Efforts: Hearing Before the Senate Special Comm. on Aging*, 107th Cong. 1 (2001) (testimony of AHA). To ensure compliance with the thicket of confusing—and sometimes conflicting—regulations comprising the Medicare reimbursement system, hospitals and other care providers regularly seek guidance from Government officials, as well as their "fiscal intermediaries"—private insurance companies under contract with the Government to process Medicare claims. *See* 42 U.S.C. § 1395h.[3] For practical reasons, however, providers cannot seek (and federal agencies and their agents are in no position to give) guidance on every last issue of regulatory interpretation that crops up when navigating Medicare's vast sea of regulations. In some circumstances, providers must simply examine and interpret the governing regulations as best they can.

When providers run afoul of Medicare's "impenetrable" regulations, *Rehabilitation Ass'n of Va.*, 42 F.3d at 1450,

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[3] A Medicare insurance carrier is "as a matter of law * * * an officer or employee of the United States." *Midland Psych. Assoc., Inc.* v. *United States*, 145 F.3d 1000, 1003 (8th Cir. 1998).

they expose themselves to potential liability under the False Claims Act, 31 U.S.C. §§ 3729 *et seq*. The Act provides for treble damages and penalties of $5,000-$10,000 for every "false claim" submitted to the Government. 31 U.S.C. § 3729(a).[4] The Act's qui tam provisions, under which private citizens may sue defendants on the Government's behalf, augment its powerful arsenal of remedies. *See* 31 U.S.C. § 3730(b). Over the past decade, False Claims Act lawsuits have proliferated. *See* W. Jay DeVecchio, *Qui Tam Actions: Some Practical Considerations*, ALI/ABA Course of Study, Health Care Law & Litigation 401 (Oct. 2001) (noting that 56 percent of qui tam cases filed since 1986 were brought in 1997 through 2000). And the fastest-growing subset of False Claims Act suits are those in the health care area.[5] The reason for the recent spate of False Claims Act suits against health care providers, some commentators argue, is "that health-care regulations have just become too complicated to understand." Uwe E. Reinhardt, *Medicare Can Turn Anyone into a Crook*, Wall St. J., Jan. 21, 2000, at A18; *see also* Joan H. Krause, *Health Care Providers And The Public Fisc: Paradigms Of Government Harm Under The Civil False Claims Act*, 36 Ga. L. Rev. 121, 146 (2001).

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[4] Department of Justice regulations increased penalties to $5,500-$11,000 for each false claim submitted on or after September 29, 1999. *See* 64 Fed. Reg. 47,099, 47,104 (Aug. 30, 1999).

[5] *See* Health, Educ. & Human Servs. Div., U.S. Gen. Accounting Office, *Medicare: Application of the False Claims Act to Hospital Billing Practices* 3 (July 1998) (noting that health care-related False Claims Act matters pending at the Department of Justice jumped from 270 matters in 1992 to over 4,000 in 1997); Dep't of Health & Human Servs. and Dep't of Justice, *Health Care Fraud and Abuse Control Program, Annual Report For FY 2001* (April 2002) (noting that "[a]t the end of 2001, [United States Attorney's Offices] had 1,746 civil health care fraud matters pending"), *available at* http://www.usdoj.gov/dag/pubdoc/hipaa01fe19.htm.

One of the Government's first False Claims Act enforcement initiatives against health care providers precipitated an important change in enforcement policy after it was criticized for labeling as "fraudulent" reasonable interpretations of ambiguous Government directives. In 1997, the Government began investigating hospitals' practice of "unbundling" laboratory tests—submitting separate bills for each procedure performed in a group of laboratory outpatient tests. During the investigation—dubbed with the military-style handle "Operation Bad Bundle"—hospitals received demand letters from United States Attorneys accusing them of having fraudulently claimed entitlement to payment for unbundled laboratory tests, demanding huge sums in repayment and penalties, and threatening law enforcement proceedings if settlement was not swiftly reached. But as an AHA report later demonstrated, the legal basis for the investigations was flawed. *See* Jones, Day, Reavis, & Pogue, Special Report to the American Hospital Association, *Development of Government Guidelines for Hospital Outpatient Laboratory Reimbursement* 45-57 (Mar. 1998). The "fraud" of which hospitals were being accused was the hospitals' allegedly failing to follow billing requirements that were never established through rulemaking, never issued as guidance by the agency, and that were actually *contradicted* in billing instructions from fiscal intermediaries. *See id.* at 55.

After the AHA and others sharply criticized "Operation Bad Bundle,"[6] then-Deputy Attorney General Eric Holder

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[6] After serious questions were raised about the Government's overreaching, the Government significantly curtailed "Operation Bad Bundle," withdrew its investigations in several states (and in one state actually refunded fines collected from hospitals), and terminated compliance agreements that were imposed as part of settlements. *See* Health, Educ. & Human Servs. Div., U.S. Gen. Accounting Office, *Medicare Fraud and Abuse: DOJ's Implementation of False Claims Act Guidance in National Initiatives Varies* 22-23 & n.11 (Aug. 1999); *Fraud and Abuse: Federal Prosecutors in Texas Back Off Operation Bad Bundle Due*

issued a memorandum specifically stating that whether a health care provider sought guidance on interpreting regulations is a critical threshold inquiry under the False Claims Act. Memorandum from Eric H. Holder, Jr., Deputy Attorney General (June 3, 1998), *reprinted at* Pet. App. 342. United States Attorneys evaluating whether a provider knowingly submitted false claims to the Government were directed, among other things, to consider whether the provider sought guidance from the "program agency or its agents":

> Did the provider directly contact either the program agency (*e.g.*, the Health Care Financing Administration [HCFA]) or its agents regarding the billing rule at issue? If so, was the provider forthcoming and accurate and did the provider disclose all material facts regarding the billing issue for which the provider sought guidance? Did the program agency or its agents, with disclosure of all relevant, material facts, provide clear guidance? Did the provider reasonably rely on such guidance in submitting the false claims? [Pet. App. 346 (Holder Memorandum at 3, para. (1)(A)(ii)(f)).]

Confronted with a knotty question of regulatory interpretation, the petitioner hospitals in this case sought guidance from one of their Medicare carriers, Travelers Insurance, on the question whether an anesthesiologist must remain at a patient's side during a procedure where a nurse-anesthetist was also present in order to certify that the anesthesiologist was "continuously involved" with that procedure. *See* Pet.

Prosecutors in Texas Back Off Operation Bad Bundle Due to Data Problems, Health Care Daily Rep. (BNA), Nov. 23, 1998, at D3. *See also* Krause, *supra*, at 146 (noting that "[o]n occasion, the government has had to retreat from high profile enforcement initiatives because of ambiguity in the reimbursement rules").

28; Pet. App. 393-400, 406.[7] Travelers instructed the hospitals that as long as anesthesiologists remained in the "operating suite"—which unrebutted evidence below established meant the hospital's complex of operating rooms and support facilities—anesthesiologists could represent that they had been "continuously involved" with a procedure. *See* 8th Cir. Appellees' App. 206 (noting that the anesthesiologist's "obligation is continuous *involvement* with the procedure, rather than, continuous *presence*") (emphasis added); *id.* at 385-387. At the petitioner hospitals' request, Travelers also sought clarification from HCFA on the same question. *Id.* at 388-389. HCFA confirmed Travelers' interpretation. *See id.* at 195-196.

The petitioner hospitals similarly sought guidance on the proper classification of nurse-anesthetist services performed in "medical necessity" cases—complicated surgeries that require two anesthesia providers. Under the controlling federal regulations, providers had two options: they could bill nurse-anesthetist services as "medically directed" or "non-medically directed." *See* 57 Fed. Reg. 33,878, 33,898-99 (July 31, 1992) (publishing 42 C.F.R. § 414.451(a)(1)-(2)). The petitioner hospitals' Medicare carriers instructed the hospitals to bill nurse anesthetist services performed in medical necessity cases as "medically directed." *See* 8th Cir. Appellees' App. 217 (Blue Cross provider manual), 381-384 (testimony of Travelers officer); *see also* 57 Fed. Reg. at 33,888 (response of HCFA to comments on proposed regulations) ("As a practical matter, as long as anesthesiologists are involved with CRNAs in anesthesia services, the CRNA would consider the procedure to be medically directed or medically supervised.").

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[7] Witnesses below testified that Medicare anesthesia regulations are the most complex of Medicare's medical specialty regulations. *See* 8th Cir. Appellees' App. 399-400, 579-580.

Respondent Minnesota Association of Nurse Anesthetists (MANA) filed a qui tam suit against the hospitals for, among other things, allegedly misrepresenting that anesthesiologists were "continuously involved" with anesthesia procedures when they were not continuously present during those procedures, and allegedly mis-billing nurse anesthetist services as "medically directed" when they were "non-medically-directed." The United States declined to intervene.

Dismissing MANA's suit, the District Court concluded that the False Claims Act's scienter requirement could not be satisfied.[8] Pet. App. 78-79. The court explained that MANA could not prove that the qui tam defendants "*knowingly* submitted false claims" when the controlling regulations were ambiguous and subject to a "range of reasonable interpretations," and when substantial record evidence demonstrated that defendants submitted their bills in accordance with Government guidance. *Id.* at 77-79.

The Eighth Circuit reversed. The court of appeals acknowledged that the False Claims Act requires relators to prove that defendants "knowingly" submitted false claims to the Government. *Id.* at 39. And the court correctly observed that the "standard for liability is knowing, not negligent, presentation of a false claim." *Id.* at 40. But the court then strayed widely from the course, stating that "while there may have been some uncertainty about the interpretation of 'continuously involved,' " the qui tam defendants "*were on*

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[8] The District Court also held that it lacked jurisdiction to hear MANA's claims because its allegations were publicly disclosed prior to the filing of the qui tam suit, and MANA—a nonprofit corporation—was not an "original source" of the disclosure. Pet. App. 65-73. And the District Court also concluded that the United States had not suffered injury as a result of the qui tam defendants' alleged fraudulent representations. *Id.* at 73-77. The Eighth Circuit reversed each of those holdings.

notice of the possibility" that their interpretation of the governing regulations was not correct. *Id.* (emphasis added). This bare "possibility," in the Eighth Circuit's view, gave rise to a "question of fact as to [petitioners'] state of mind," and required remand to the District Court for trial. *Id.*

That is quite plainly not the standard to which petitioners should have been held. The Eighth Circuit's formulation brings the court into sharp conflict with the holdings of several other courts of appeal, all of which have made clear that a qui tam defendant cannot be found *knowingly* to have submitted false claims when it was following—with Government guidance, no less—a reasonable interpretation of ambiguous controlling regulations.

SUMMARY OF ARGUMENT

Hospitals and other care providers strive daily to comply with Medicare's intricate web of reimbursement regulations. They seek guidance from federal agencies and their fiscal intermediaries, and they employ their best judgment to render reasonable interpretations of the regulations' complicated and often conflicting directives. Occasionally their interpretations turn out to be wrong. That does not make them "knowingly false." But by holding that the petitioners "were on notice of the possibility" of a different interpretation of the controlling regulations, the Eighth Circuit has allowed False Claims Act relators to bring their claims to a jury even where the relators lack *any* evidence that the claims were "knowingly false."

The Eighth Circuit's decision conflicts with the holdings of several other courts of appeal. Those courts have consistently held that False Claims Act defendants who seek out and reasonably rely on government guidance, or who demonstrate that they reasonably interpreted their governing regulations, are entitled to summary judgment, on grounds that the Act's scienter requirement cannot be met in those circumstances. The Eighth Circuit's decision substantially lowers

the bar for sending False Claims Act cases to the jury, and it does a grave disservice to hospitals and care providers making every reasonable attempt to comply with the morass of Medicare regulations to which they are subject.

ARGUMENT

QUI TAM DEFENDANTS WHO REASONABLY RELY ON GOVERNMENT GUIDANCE ARE ENTITLED TO SUMMARY JUDGMENT.

1. The False Claims Act ("Act") prohibits any person from "knowingly" presenting a "false or fraudulent" claim to the government. 31 U.S.C. § 3729(a). The Act defines "knowing" as actual knowledge of the falsity of the information, or deliberate ignorance or reckless disregard of the truth or falsity of the information presented to the government. 31 U.S.C. § 3729(b).

The Act's scienter requirement, as one court has observed, is "critical" to its operation. *United States ex rel. Hochman* v. *Nackman*, 145 F.3d 1069, 1073 (9th Cir. 1998). Innocent or negligent mistakes do not give rise to False Claims Act liability. *See United States ex rel. Oliver* v. *Parsons Co.*, 195 F.3d 457, 464-465 (9th Cir. 1999), *cert. denied*, 530 U.S. 1228 (2000). Rather, the Act requires that the defendant made a "*knowing* presentation of what is *known* to be false." *Hagood* v. *Sonoma County Water Agency*, 81 F.3d 1465, 1478 (9th Cir.) (quotation omitted and emphases added), *cert. denied,* 519 U.S. 865 (1996). "In short, the claim must be a lie." *Hindo* v. *University of Health Sciences/The Chicago Med. Sch.*, 65 F.3d 608, 613 (7th Cir. 1995), *cert. denied*, 516 U.S. 1114 (1996). Thus, as the Ninth Circuit has explained, "[a] contractor relying on a good faith interpretation of a regulation is not subject to liability, not because his or her interpretation was correct or 'reasonable' but because the good faith nature of his or her action forecloses the possibility that the scienter requirement is met." *Oliver*, 195 F.3d at 464. *See also United States ex rel. Mikes* v. *Straus*,

274 F.3d 687, 703 (2d Cir. 2001); *Wang* v. *FMC Corp.*, 975 F.2d 1412, 1420 (9th Cir. 1992).

As the Eighth Circuit framed the issue, the inquiry into the defendants' intent turned on whether defendants were "on notice of the possibility" that the controlling regulations might be interpreted in a manner inconsistent with their billing practices. Pet. App. 39-40. But it is not enough under the FCA for the defendant to be "on notice" of the possibility that the regulations may be interpreted to prohibit its conduct. The proper inquiry in this situation, rather, is whether the defendants reasonably relied on the guidance provided by the Government and its agents regarding billing for anesthesia services. As other courts have recognized, when a provider seeks guidance from the Government or its agent about an ambiguous regulation and acts in accordance with that guidance, the provider should be entitled to a presumption that claims submitted subject to that guidance were not knowingly false such that, absent specific rebuttal evidence, the provider is entitled to summary judgment.

This standard is not a free pass for False Claims Act defendants to automatically avoid liability at the summary judgment stage by concocting a post-hoc interpretation of an ambiguous regulation that is consistent with their conduct.[9] Rather, it properly allocates the burden of proof between the

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[9] The United States filed an amicus brief in the Eighth Circuit warning that an overly broad reading of the District Court's opinion might improperly "absolve of liability any defendant who can advance, post-hoc, a plausible regulatory basis for his submission of admittedly false claims." Brief of Amici Curiae United States at 26, *United States ex rel. Minnesota Ass'n of Nurse Anesthetists* v. *Allina Health Sys. Corp.*, 276 F.3d 1032 (8th Cir. 2002). That concern is not present in this case, where, as the District Court recognized, the defendants submitted "substantial evidence" that their interpretation of the regulations was not only reasonable, but was formed contemporaneously with their claim submissions and with Government guidance. *See* Pet. App. 78.

relator and the defendant in circumstances where the defendant has taken reasonable steps prior to submitting its claims to ensure their propriety.

2. Courts have repeatedly endorsed the principle that individuals should be allowed to act on legal guidance from the Government without fear of retribution, both in the context of the False Claims Act and well beyond.[10] *See United States* v. *Levin*, 973 F.2d 463 (6th Cir. 1992). The defendant physicians in *Levin*, charged with violations of the False Claims Act's criminal analog,[11] had participated in a marketing arrangement with suppliers of lens implants where the physicians received disposable surgical supplies with each purchase of a lens implant. *Id.* at 464. Before they implemented the arrangement, the suppliers had sought guidance from HCFA and had received assurances that the arrangement was legal. *Id.* at 465. Although the defendants themselves had not sought guidance on the issue, the HCFA opinion letters were circulated throughout their professional community. *Id.* When the physicians were later charged with making false claims, the district court dismissed the charges prior to trial. The Sixth Circuit affirmed, concluding that "the defendants and those similarly situated could not, as a matter of law, have formulated the necessary intent" to violate the Medicare fraud statute. *Id.* at 466.

The principle on which *Levin* turned—that individuals may defend against allegations of making false claims by pointing

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[10] The principle has its roots in due process concerns in the criminal context. *See United States* v. *Laub*, 385 U.S. 475, 487 (1967) ("Ordinarily, citizens may not be punished for actions undertaken in good faith reliance upon authoritative assurance that punishment will not attach.").

[11] The *Levin* defendants were charged with violations of 42 U.S.C. § 1395nn(b)(1)(B) (Medicare fraud); 18 U.S.C. § 287 (false claims); 18 U.S.C. § 1001 (false statements); and 18 U.S.C. § 1341 (mail fraud). 973 F.2d at 464.

to their reliance on Government guidance—has been repeatedly applied in civil False Claims Act cases. In *Hindo* v. *Univ. of Health Sciences/The Chicago Medical School*, 65 F.3d at 614, for example, a university billed a Veteran's Administration (VA) medical center for two radiology residents for whom the VA had not approved funding. In a subsequent False Claims Act qui tam suit, the Seventh Circuit upheld a directed verdict in the university's favor, noting that the university had been led to believe by the VA that the required funding would eventually be approved. *Id.* The Seventh Circuit concluded that "[n]o legitimate reading of the record can support an inference that [the university] *knew* that the possibility of funding was foreclosed" and nonetheless submitted false claims for reimbursement. *Id.* at 613-614 (emphasis added). Where the Government had given the university assurances that the positions would be funded, even if those assurances ultimately did not bear fruit, "[i]t was not unreasonable and certainly not fraudulent" for the university to submit claims for reimbursement for the unfunded residents. *Id.* at 614. At most, the court noted, the university was "perhaps negligent in not ascertaining whether funding had been approved * * *. But negligence is not actionable." *Id.*

Similarly, in *Hagood* v. *Sonoma County Water Agency*, 81 F.3d at 1478, the Ninth Circuit upheld summary judgment for the defendant in a False Claims Act case where the defendant had relied upon the Government's interpretation of the relevant regulation. At issue there was an agreement between a county and the Army Corps of Engineers for the county to reimburse the Corps for the water supply component of the cost of building a dam. *Id.* at 1467. The county based its reimbursement payment on an outdated cost allocation that was admittedly imprecise, if not flat wrong. *Id.* at 1477. The Corps told the county, however, that no new cost allocation would be performed. *Id.* at 1478.

Noting that the county "did merely what the Corps bid it do," the Ninth Circuit affirmed judgment for the defendant. *Id.* (quotation omitted). Whether the Corps was required to

perform a new, updated cost allocation better reflecting current data was, according to the evidence, a "disputed question within the Corps." *Id.* at 1477. By acting in reliance on the Corps' statement that it would not perform a new cost allocation, the defendant may have "take[n] advantage of a disputed legal question," but that was fair game under the Act; making the most of an uncertain legal issue did not render the defendant's actions so "deliberately ignorant nor recklessly disregardful" as to satisfy the Act's scienter requirement. *Id.* at 1478 (quotation omitted). *See also United States ex rel. Lamers* v. *City of Green Bay*, 998 F. Supp. 971, 991 (E.D. Wis. 1998) ("Exploring the boundaries of a disputed legal question is not actionable under the FCA"), *aff'd*, 168 F.3d 1013 (7th Cir. 1999).

Finally, in a case bearing many similarities to this one, *United States ex rel. Swafford* v. *Borgess Medical Center*, 98 F. Supp. 2d 822 (W.D. Mich. 2000), *aff'd*, 2001 WL 1609913 (6th Cir. 2001), *cert. denied*, 122 S. Ct. 2292 (2002), the defendant physicians were accused by a qui tam relator of submitting false claims for reimbursement for their evaluation of vascular ultrasounds. Under the controlling Medicare regulations, different billing rates applied depending on whether the ultrasound was performed and evaluated by a technician or a physician. *Id.* at 825. Technicians performed the actual tests, reviewed the data, and created a summary. Physicians based their reports on the technicians' worksheets. *Id.* The relator claimed that the physicians falsely billed for more expensive "professional" services, rather than "technical" interpretations, when they merely copied their conclusions from the technicians' summaries. *Id.* at 826.

The district court granted summary judgment for the defendants. First of all, the court noted, the question whether interpreting a technician's summary amounted to "professional" services was really a "dispute over the meaning of the terms governing the delivery of the professional component of physician services." *Id.* at 831-832. Such a "legal dispute" was insufficient to establish the *falsity* of a claim under

the False Claims Act. *Id.* at 832 (citing *Hagood*, 81 F.3d at 1477). Nor, the district court went on, could the relator prove scienter: the evidence showed that one defendant had sought guidance from HCFA about the proper billing modifier to use in such circumstances, and HCFA had responded that there were no specific guidelines published on the question. *Id.* at 832-833. The court observed that defendants' attempts to secure guidance from HCFA "suggests defendants evinced concern and investigated the question of what procedures were required to submit a proper claim for reimbursement." *Id.* at 833. Finding no other affirmative evidence—other than the relator's own bald speculation—suggesting that the defendants' practice recklessly disregarded applicable billing regulations, the court granted judgment for defendants. *Id.*

In each of these cases, as here, the evidence demonstrated that there existed a legal ambiguity in the governing regulations. In each case, the defendants were aware of the uncertainty in the law—that is, they were "on notice of the possibility" of a different interpretation of the regulations at the time they submitted their claims. In each case, the defendants either specifically sought guidance from the Government or relied upon representations made to others by the Government when submitting their claims. And in each case, the courts shielded the defendants from a False Claims Act trial by granting summary judgment in their favor. Consistent with the standard offered herein, and contrary to the approach taken by the Eighth Circuit, the courts recognized that unrebutted evidence of seeking and reasonably relying upon Government guidance created a strong presumption that any claims submitted pursuant to that guidance were not knowingly false.[12]

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[12] Indeed, even in denying or overturning judgment for a False Claims Act defendant on the scienter element, courts have emphasized the importance of seeking clarification from the Government of ambiguous regulations, noting that the outcome may have favored the defendants if they had affirmatively sought such clarification. *See, e.g., United States* v. *Cooperative Grain & Supply Co.*, 476 F.2d 47, 60 (8th Cir. 1973) (holding that the

3. MANA suggested to the courts below that the petitioners' interpretation of the regulations, even if reasonable, would not absolve them from False Claims Act liability. To begin with, it would be highly impracticable, if not impossible, for regulated entities to seek clarification from the Government on every ambiguity in their governing regulations. Courts have recognized as much, holding that even where False Claims Act defendants have *not* affirmatively sought specific guidance from the Government on the proper interpretation of a controlling regulation, evidence of a defendant's contemporaneous reasonable or good-faith belief that its interpretation was reasonable negates the False Claims Act's scienter element.

In *United States ex rel. Hochman* v. *Nackman*, 145 F.3d at 1075-76, for example, the Ninth Circuit held that where the defendants believed their conduct was authorized under a contract with the Government, the defendants were entitled to summary judgment. The relators in *Hochman* claimed, among other things, that the defendant hospital administrators and physicians had billed a VA clinic for times when the physicians were not physically present at the clinic. *Id.* at 1070.[13] The Affiliation Agreement under which the physicians provided their services did not address whether physicians would be paid for time they spent teaching or performing research outside the VA facility; the defendants had interpreted the Agreement to allow for such activities to be compensated. *Id.* at 1075.

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extreme carelessness with which the defendants submitted their claims satisfied the Act's scienter requirement, and noting that the case would "have been much different if the defendants at least had" sought clarification of the governing regulations).

[13] The relators in *Hochman* claimed that the defendants had violated the False Claims Act in three other respects as well. The Ninth Circuit concluded as to each of those three charges that the Act's scienter requirement was not satisfied. *See id.* at 1073-75.

Without deciding whether the defendants' interpretation of the Affiliation Agreement was wrong or right, the Ninth Circuit upheld summary judgment in favor of the defendants. The court of appeals noted that "the undisputed evidence demonstrates that the defendants believed that the Affiliation Agreement authorized their conduct." *Id.* The court further concluded that regardless of whether defendants' interpretation ultimately was incorrect, it was "at least superficially plausible" and was not "in reckless disregard of or deliberate indifference to" the controlling language. *Id.* "Without sufficient evidence to support an inference that the defendants understood that they were interpreting the Affiliation Agreement incorrectly," the court concluded, "the plaintiffs' claim must fail." *Id.* at 1076. *See United States ex rel. Mikes* v. *Straus*, 274 F.3d at 704 (upholding summary judgment for defendants where defendants proffered "ample evidence—most of which derives from disinterested non-party witnesses—supporting their contention that they held a good faith belief" that their Medicare reimbursement requests were legitimate); *United States ex rel. Norbeck* v. *Basin Elec. Power Coop.*, 248 F.3d 781, 793-794 (8th Cir. 2001) (reversing judgment against defendant; while rules governing defendant's practices were not clear, plaintiffs introduced no evidence from which an inference could be drawn that defendant *knew* it was overcharging the Government), *cert. denied*, 122 S. Ct. 924 (2002); *Lamers*, 998 F. Supp. at 991 (granting summary judgment for defendants where evidence showed that defendants were genuinely confused about the regulatory requirements at the time they submitted the allegedly false claims, and no evidence supported relator's claim that defendants had feigned ignorance in an elaborate scheme to defraud the government).

4. The relator below—and the United States as amicus curiae, *see supra* n.9—relied heavily on the Ninth Circuit's opinion in *United States ex rel. Oliver* v. *Parsons Co.*, 195 F.3d at 463, to support their contention that the defendants'

reasonable interpretation of the anesthesia regulations did not excuse them from liability. Far from supporting the relator's position here, *Oliver* in fact confirms that where defendants produce credible unrebutted evidence of their good-faith interpretation of a governing regulation—as the hospital defendants did in this case—they are entitled to summary judgment.

Oliver held that the *falsity* element of the False Claims Act cannot be satisfied merely by showing that the defendant employed a "reasonable interpretation" of the controlling regulations. *See* 195 F.3d at 460. That makes sense. A court reviewing a False Claims Act charge must interpret the governing regulations and determine whether a claim was false, and a "reasonable interpretation" standard would improperly trump that inquiry.

The primary question in this case, however, was not whether the defendant hospitals' interpretation of the anesthesia reimbursement rules negated the Act's falsity element, but whether the Act's *scienter* requirement was defeated when the defendant hospitals produced unrebutted evidence that they sought and reasonably relied on Government guidance in interpreting those regulations. *See* Pet. App. 77-78 (District Court decision addressing defendants' "intent to submit false claims"); *id.* 39 (Eighth Circuit opinion addressing intent element). The Ninth Circuit's "reasonable interpretation" discussion does not impact that question in the least, and its treatment of the scienter element squares with that of other circuits (except, of course, the Eighth). The *Oliver* panel concluded that a trial was required on the scienter element Act because the relator had produced compelling evidence of knowledge sufficient to preclude summary judgment.[14] Unlike the relator in *Oliver*, MANA in

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[14] The relator, an accountant at the defendant company, submitted an affidavit stating that when she brought the omission giving rise to the False Claims Act action to defendant's corporate

this case submitted *no* evidence that the defendant hospitals actually *knew* their interpretations of the governing regulations were wrong and that their Medicare reimbursement requests were false. Rather, as in *Hochman*, *Mikes*, and *Norbeck*, the hospitals offered substantial credible evidence that they reasonably interpreted the anesthesia regulations before they submitted their reimbursement claims.

CONCLUSION

For the foregoing reasons, as well as those presented in the petition, the petition should be granted and the Eighth Circuit's decision reversed.

Respectfully submitted,

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officers, she was told to "forget about it," and was further told that the omission was purposeful to allow the defendant to charge the government a higher rate for its services. 195 F.3d at 465.

(5)

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In The

Supreme Court of the United States

ALLINA HEALTH SYSTEM CORP., et al.,

Petitioners,

v.

UNITED STATES OF AMERICA,
EX REL. MINNESOTA ASSOCIATION OF
NURSE ANESTHETISTS,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

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ARGUMENT

I. THE EIGHTH CIRCUIT IMPERMISSIBLY DEVIATED FROM THE PLAIN MEANING OF THE FALSE CLAIMS ACT'S JURISDICTIONAL PROVISIONS

Petitioners argued that the federal courts lacked subject matter jurisdiction over this action because the lower courts found it to be one based upon prior public disclosures, namely an earlier filed antitrust action and news reports, and because the respondent Minnesota Association of Nurse Anesthetists ("MANA") could not come within the False Claims Act's ("FCA" or "Act") definition of an "original source," 31 U.S.C. § 3730(e)(4)(B), entitled to maintain a qui tam action in those circumstances. Pet. 7-18. MANA defends the Eighth Circuit's conclusions that a trade association is "an individual," and that an association impliedly shares the direct knowledge of all its members, and claims the Eighth Circuit was justified in splitting with the D.C. and Sixth Circuits on the pre-suit disclosure required of an original source. Br. Opp. at 5-16. Respondent identifies no unresolved factual issues that preclude review by this Court now of these threshold jurisdictional questions.

A. MANA Is Not An Individual

Relying on the plain meaning of the words "an individual" in the False Claims Act's definition of "original source," 31 U.S.C. § 3730(e)(4)(B); the Dictionary Act, 1 U.S.C. § 1; long-held canons of statutory construction; and this Court's recent decision in *Vermont Agency of Natural Res. v. United States ex rel. Stevens*, 529 U.S. 765, 786 and n.17 (2000), petitioners argued that the nonprofit corporation MANA was not "an individual," and there the statutory and jurisdictional inquiry must end. Pet. 9-13. MANA responds first by contending that restricting "individual"

to its plain meaning of a natural person "would dramatically restrict the ability of persons with direct knowledge of fraud to recover damages on behalf of the Government." Br. Opp. 6. MANA misperceives Congress's intent in the False Claims Act. The Act is principally aimed at apprising the government of the existence of false claims and ensuring the government's ability to recover overpayments, not with enriching private qui tam relators. Pet. 7. The entire original source inquiry presumes that a prior public disclosure of allegations of fraud has occurred, enabling the government to proceed directly if the allegations have merit, without relying on a relator's knowledge. No policy preference of qui tam relators can justify ignoring the plain meaning of the statutory term restricting original source status to "an individual," *Barnhart v. Sigmon Coal Co.*, 122 S. Ct. 941, 956 (2002), and the government loses no opportunity to pursue otherwise undisclosed fraud through reading the original source provision according to the plain meaning of its terms.[1]

The cases cited by respondent in support of the Eighth Circuit's interpretation do not address congressional intent in confining original source status to individuals. Br. Opp. 6-7. They also predate *Stevens*, which holds that "individual" in the context of the False Claims Act has its

[1] While resort to legislative history is not proper as the statute is plain on its face, the limited discussion of qui tam relators in the FCA's history focuses on encouraging individuals with knowledge of fraud to come forward, not providing associational litigants with additional remedies. *See, e.g.*, S. Rep. No. 99-345, at 14 (1986) (noting testimony that "private individuals" need a vehicle to disclose fraud and to break "the current 'conspiracy of silence' among Government contractor employees").

ordinary definition, distinct from corporations, associations or other private organizations. 529 U.S. at 786 and n.17.[2]

B. MANA Has No Direct Knowledge

Petitioners argued that, as a nonprofit corporation, MANA does not possess the "direct . . . knowledge of the information on which the allegations are based," 31 U.S.C. § 3730(e)(4)(B), necessary to be an original source. At most, MANA could only share direct knowledge with its authorized agents, and MANA's certified registered nurse anesthetist ("CRNA") members were agents of their hospital employers when they allegedly observed false claims. Pet. 13-15.

MANA supports its claim of direct knowledge of false claims by contending that,

> the record shows that MANA itself engaged in an independent investigation of Petitioners' fraud.

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[2] Two of the appellate cases cited by MANA, *United States ex rel. Plumbers and Steamfitters Local Union No. 38 v. C.W. Roen Constr. Co.*, 183 F.3d 1088 (9th Cir. 1999), and *United States ex rel. S. Prawer & Co. v. Fleet Bank*, 24 F.3d 320 (1st Cir. 1994), do not reach the original source issue at all. *United States ex rel. Durcholz v. FKW, Inc.*, 997 F. Supp. 1159, 1166 (S.D. Ind. 1998), *aff'd*, 189 F.3d 542 (7th Cir. 1999), plainly focuses on the individual relator Robert Durcholz in finding original source status.

United States v. Middleton, 231 F.3d 1207 (9th Cir. 2000), does not support the conclusion that a trade association or corporation can be an "individual" within the meaning of 31 U.S.C. § 3730(e)(4)(B). Br. Opp. 7 n.6. The Ninth Circuit in *Middleton* concedes that "the Dictionary Act's [1 U.S.C. § 1] definition of 'person' implies that the words 'corporations' and 'individuals' refer to different things," 231 F.3d at 1211, but claims an exception to the plain meaning may apply based on "the texts of other related congressional acts," *id.*, citing *Rowland v. California Men's Colony*, 506 U.S. 194, 199 (1993). In *Stevens* this Court determined that in the FCA an individual is distinct from a corporation or association.

> This investigation included interviewing its members, hiring of attorneys to research the law, and gathering evidence. . . .

Br. Opp. 11. MANA's contention that a relator can gain direct knowledge of allegations of false claims by hiring lawyers and investigating a third party's claim is not the law in any circuit. *See United States ex rel. Barth v. Ridgedale Elec., Inc.*, 44 F.3d 699, 703 (8th Cir. 1995) ("A relator is said to have direct knowledge of fraud when he saw it with his own eyes. . . . On the other hand, a person who obtains secondhand information from an individual who has direct knowledge of the alleged fraud does not himself possess direct knowledge and therefore is not an original source under the Act. Accordingly, collateral research and investigations . . . [do] not establish direct and independent knowledge of the information on which the allegations are based within the meaning of § 3730(e)(4)(B).") (citations and quotations omitted).

Respondent's fallback position is to assert "associational standing." Br. Opp. 11-12 and n.11. That constitutional doctrine does not supersede the express statutory proscriptions on federal jurisdiction crafted by Congress in the False Claims Act. The statute governs. MANA is a Minnesota nonprofit corporation. Pet. App. 352.[3] Under Minnesota law the members of a nonprofit corporation are not the agents of the corporation. Pet. 14. MANA does not share whatever direct knowledge its CRNA members may have of purported false claims.[4]

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[3] Respondent speciously asserts a "dispute below as to the corporate status of MANA." Br. Opp. 13 n.12. MANA's articles of incorporation are public records, and MANA cannot deny its corporate existence.

[4] Also irrelevant to the jurisdictional inquiry is whether "MANA's express purpose was to promote the practice of anesthesia and to support nurse anesthetists to provide anesthesia in hospitals." Br.

(Continued on following page)

C. The Circuits Are Split On The FCA's Pre-suit Disclosure Requirements

The Eighth Circuit acknowledges that its decision creates a split between itself and the D.C. and Sixth Circuits on the pre-suit disclosure requirements imposed by 31 U.S.C. § 3730(e)(4)(B) on original sources. Pet. App. 34. As MANA's only pre-suit disclosure to the government post-dated the public disclosure of the allegations at issue, MANA could not be an original source in the D.C. or Sixth Circuits. Pet. 16-18. Respondent contends that no circuit split "warranting review" exists. Br. Opp. 13.

The importance of the split in the circuits on the pre-suit disclosure requirements is obvious and worthy of review. The Eighth Circuit has allowed MANA to proceed as an original source relator in a case which seeks over $1,000,000,000 in damages and fines. Given MANA's failure to provide the government with any nonpublic information regarding its members' allegations before filing suit, the Sixth and D.C. Circuits would have affirmed the dismissal of MANA's claim for lack of subject matter jurisdiction. Such gross disparities in health care providers' potential liabilities by geographical happenstance warrants this Court's review.[5]

Opp. 12 n.11. A corporate entity's organizational purpose will not allow it to evade the restrictions on federal jurisdiction embodied in 31 U.S.C. § 3730(e)(4)(B). *Cf. Federal Recovery Services, Inc. v. United States*, 72 F.3d 447, 452 (5th Cir. 1995) (finding relator that was "incorporated with the express purpose of pursuing qui tam litigation based on the information that others . . . had already obtained," had no direct and independent knowledge and was not an original source).

[5] While MANA claims to have provided nonpublic information to the government before filing the qui tam complaint, Br. Opp. 16 n.15, the Eighth Circuit's review of MANA's extensive filings determined only

(Continued on following page)

Respondent's policy argument that the rule of the Sixth and D.C. Circuits would unfairly deny relators their share of any False Claims Act recovery again demonstrates a misapprehension of the Act's goals. Br. Opp. 15. By precluding original source relators from proceeding if they do not disclose their knowledge to the government before public disclosure has occurred, the Sixth and D.C. Circuits simply recognize that the government can fully investigate publicly disclosed allegations and need not share recovery of the government's funds in such a case with any relator.

II. ARTICLE III DOES NOT PERMIT QUI TAM RELATORS TO PURSUE ABSTRACT CLAIMS WHERE NO INJURY HAS OCCURRED

Petitioners presented the law holding that an Article III case or controversy exists only in the presence of an injury in fact; that in the context of the False Claims Act, a qui tam relator has standing only as an assignee of a portion of the government's claim for money damages, *Stevens*, 529 U.S. at 771; and that the government's damages are measured by the amount the government paid out by virtue of the false claim over and above what it would have paid had the claim been truthful. Pet. 18. Petitioners pointed out that both under the statutory language of 31 U.S.C. § 3729(a) and this Court's holding in *United States v. Bornstein*, 423 U.S. 303 (1976), absent conspiracy, a person is liable only for her own conduct, not that of others who have allegedly filed false claims. Pet. 19. Respondent sidesteps these propositions of law

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that MANA had provided the government with a copy of its already public antitrust complaint before filing the FCA complaint. Pet. App. 34.

with a long string citation of pre-*Stevens* cases to argue that, "the False Claims Act clearly provides for recovery against defendants who submit false claims whether or not those false claims are ever paid." Br. Opp. 17 and n.16.

The hospital petitioners do not contend that they did not receive payment on their claims alleged to be false – claims for the services of CRNA employees when it was medically necessary for both an anesthetist and an anesthesiologist to devote their attention to a single case. Pet. App. 300-301. *See also* 42 C.F.R. § 414.46(c)(3) (1991), Supp. App. 3. Rather, the petitioners point out that there is no allegation that the nurses did not provide anesthesia services, *id.*;[6] that the hospitals billed for those services at the lower of the only two available rates for CRNAs, Pet. App. 372-373, 457-465; and that the Minnesota Medicare carriers intended that these claims be filed and paid at the lowest available rate, Pet. App. 333-335 and Supp. App. 7-8. MANA does not dispute these facts. MANA's contention that the hospitals billed falsely because they should have billed at the higher rate provided for nonmedically directed CRNA services is an artificial dispute in the air – the government obtained a hospital service, nurse anesthesia, at the lowest available rate.[7] Trumped up claims of false underbilling are exactly the sort of theoretical

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[6] MANA again states, "It is [the] nurses that provided the services which Petitioners falsely represented had been provided by the doctors." Br. Opp. 11.

[7] The Eighth Circuit's error, abetted by the respondent and the United States as amicus below, is to find injury to the government from the hospital petitioners based not on their own bills for employee CRNA services, but by claiming that the independent anesthesiologists' billing caused the government to pay more than necessary for both providers' services taken together. With no evidence of conspiracy, Pet. App. 47-48, there is no basis in the False Claims Act for aggregating the hospitals' and the independent physicians' bills in this manner.

dispute without injury to the government that Article III precludes federal courts from entertaining.

III. THE EIGHTH CIRCUIT'S RULING CONFLICTS WITH OTHER CIRCUITS ON THE FCA'S FALSITY AND INTENT REQUIREMENTS

Petitioners argued that the Eighth Circuit improperly reversed summary judgment on alleged violations of the False Claims Act when no regulation or other source of law clearly prohibited the conduct alleged. Such a showing of falsity is an essential element of a False Claims Act violation as the law has developed in other circuits. Pet. 22-26. MANA does not refute petitioners' contention that the Medicare regulations at issue do not explicitly prohibit the conduct alleged to violate the FCA, and does not deny that the Eighth Circuit's ruling differs from other circuits in failing to address the threshold legal issue of falsity.

Petitioners also argued that the Eighth Circuit's ruling splits with other circuits in holding that reliance on contemporaneous government advice in filing claims does not as a matter of law negate the intent required for False Claims Act liability. Pet. 26-29; see also *Amici* Pet. 11-20. Petitioners demonstrated that between 1991 and 1993 Travelers, the local Medicare carrier for the Twin Cities, informed both hospitals, Pet. App. 382-389, and physicians, Pet. App. 469-472, who inquired that the phrase "continuously involved" in 42 C.F.R. § 414.46(c)(2)(ii) (1991), Supp. App. 2, did not require an anesthesiologist's constant physical presence in the operating room in order to bill a case as personally performed; that this interpretation was common among carriers nationally, App. 393-410; and that it was confirmed in 1993 by the Health Care Financing Administration ("HCFA"), Pet. App. 390-392.

See also Amici Pet. 7-8. Respondent does not contest these facts, but contends that in the late 1980s the other Minnesota carrier, Blue Cross Blue Shield, published a different interpretation of the requirements for personal performance billing, and that HCFA itself later (after commencement of this litigation) agreed with MANA's interpretation of the regulation at issue. Br. Opp. 19.[8]

There is no doubt that the Medicare bureaucracy – HCFA and the carriers – was in fundamental disarray as to the meaning of its anesthesia billing regulations during the early 1990s, the period covered by MANA's action. A person cannot be liable for knowingly violating regulations for which the government has no consistent interpretation.

The Second, Seventh, and Ninth Circuits have recognized, as a matter of law, that claims submitted in accordance with governmental guidance cannot meet the standard of scienter required by the False Claims Act. Pet. 26-29. As the amicus petition of the American Hospital Association and the Catholic Health Association of the

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[8] Respondent mischaracterizes the record in its Brief in Opposition at 21 n.17 (among other ways by citing to the deposition of a Travelers official, Patrick Donohue, to claim admissions by Dan Roach, an in-house attorney for petitioner Allina Health System). As the correspondence at Pet. App. 382-389 shows, petitioner Allina fairly presented the issues surrounding personal performance billing to the carrier, and was told the physician need not be constantly present in such a circumstance. Mr. Roach testified that Allina was "in the position of relying on the advice that [Travelers] had given me." Appellees' Appendix to the Eighth Circuit (Oct. 14, 1999) at 625-626.

The Brief for Appellees to the Eighth Circuit (Oct. 14, 1999) at 11-16 details the full history of Travelers' interpretations and the 1992-1993 direction on personal performance billing given by the other Minnesota carrier, Blue Cross Blue Shield (which contradicts the memos from the late 1980s MANA cites, Br. Opp. 19), and each defendant group's reliance on one or another HCFA or carrier communication.

United States shows, the Eighth Circuit's contrary ruling creates a circuit split with national importance to health care providers, worthy of this Court's review.

CONCLUSION

For the foregoing reasons and those stated in the petition, it is respectfully submitted that the petition for a writ of certiorari should be granted.

Dated: August 19, 2002

Respectfully submitted,

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* The current form of 42 C.F.R. § 414.46 is reprinted in Petitioners' Appendix at 149-154.

§ 41[4].46 Additional rules for payment of anesthesia services.

(a) *Definitions.* For purposes of this section, the following definitions apply:

(1) *Base unit* means the value for each anesthesia code that reflects all activities other than anesthesia time. These activities include usual pre-operative and post-operative visits, the administration of fluids and/or blood incident to anesthesia care, and monitoring procedures.

(2) *Time units* involve the continuous actual presence of the physician (or of the medically directed qualified anesthetist or resident) and start when he or she begins to prepare the patient for anesthesia care and ends when the anesthesiologist (or medically directed CRNA) is no longer in personal attendance, that is, when the patient may be safely placed under post-operative care.

(b) *General rules.*

(1) For physician anesthesia services furnished beginning January 1, 1992, HCFA bases payment on the lesser of the actual charge or the physician fee schedule amount in accordance with § 415.20.

(2) The physician fee schedule amount is based on the product of allowable base and time units and an anesthesia-specific CF [Conversion Factor].

(3) The allowable base units are determined by the uniform relative value guide based on the 1988 American Society of Anesthesiologists' Relative Value Guide except that the number of base units recognized for anesthesia services furnished during cataract or iridectomy surgery is

four units. The uniform base units are identified in program operating instructions.

(c) *Physician personally performs the anesthesia procedure.* (1) HCFA determines the fee schedule amount for anesthesia procedures personally performed by a physician on the basis of an anesthesia-specific fee schedule CF and unreduced base units and anesthesia time units. For purposes of this paragraph, one anesthesia time unit is equivalent to 15 minutes of anesthesia time, and fractions of a 15-minute period are recognized as fractions of an anesthesia time unit.

(2) HCFA considers an anesthesia procedure to be personally performed by a physician if it meets one of the following circumstances:

(i) The physician personally performs the entire anesthesia procedure.

(ii) The physician is continuously involved in a single case involving a certified registered nurse anesthetist (CRNA), anesthesiologist assistant (AA), or student nurse anesthetist.

(iii) For services furnished before January 1, 1994, the physician establishes an attending physician relationship in one or two concurrent cases involving an intern or resident as described in § 405.521 of this chapter. HCFA pays the full fee in each of these two concurrent cases. If the physician is involved in two concurrent cases with interns or residents after December 31, 1993, the payment rules in paragraph (d) of this section apply. (If the physician is involved in two concurrent procedures, one of which involves an intern or resident and the other a nonphysi-

cian anesthetist, the payment rules in paragraph (d) of this section apply.)

(3) No payment is made under the CRNA fee schedule for the services of a CRNA or AA involved in a procedure described in paragraph (c)(2) of this section unless HCFA determines that it was medically necessary for both the physician and the CRNA or AA to be involved in the same case.

(d) *Physician medically directs concurrent anesthesia procedures.* HCFA determines the fee schedule amount for concurrent medically directed anesthesia procedures furnished by a physician based on the anesthesia-specific fee schedule CF, reduced base units, and anesthesia time units. For purposes of this paragraph, one anesthesia time unit is equivalent to 30 minutes of anesthesia time, and fractions of a 30-minute period are recognized as fractions of an anesthesia time unit. The base unit of each concurrent medically directed anesthesia procedure furnished by a physician is reduced by the following percentages:

(1) Two procedures – 10 percent.

(2) Three procedures – 25 percent.

(3) Four procedures – 40 percent.

(4) If cataract or iridectomy anesthesia is one of the concurrent medically directed anesthesia procedures – 10 percent.

(e) *Physician medically supervises anesthesia procedures.* If the physician medically supervises more than four concurrent anesthesia procedures, HCFA bases the fee schedule amount on an anesthesia-specific CF and

three base units. This represents payment for the physician's involvement in the pre-surgical anesthesia procedures.

(f) *Payment for medical or surgical services furnished by a physician while furnishing anesthesia services.* (1) HCFA allows separate payment under the fee schedule for certain reasonable and medically necessary medical or surgical services furnished by a physician while furnishing anesthesia services to the patient. HCFA makes payment for these services in accordance with the general physician fee schedule rules in § 415.20. These services are described in program operating instructions.

(2) HCFA makes no separate payment for other medical or surgical services, such as the pre-anesthetic examinations of the patient, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service.

(g) *Physician involved in multiple anesthesia services.* If the physician is involved in multiple anesthesia services for the same patient during the same operative session, the carrier makes payment according to the base unit associated with the anesthesia procedure having the highest base unit value and anesthesia time that encompasses the multiple procedures.

In The United States District Court
District of Minnesota

MANA, et al. vs. Unity Hospital, et al.

Deposition of Patrict Donohue-1/8/98

Donohue, Patrick V01 01/08/98

* * *

[27] A It's a bulletin that we issued to anesthesia providers in 1989.

Q I believe this was the earliest of the provider bulletins that you produced in connection with response to the subpoena, is that correct, earliest in time?

A It could be, yes.

Q Could you direct your attention to the second page of the exhibit, I guess it's page 3 of the document?

A (Examining document.)

Q Was the document responsive to the subpoena because of the material at the top of the page 3 beginning when an anesthesiologist and an anesthetist are both involved in a single procedure?

MR. STONE: Object to the form of the question.

A The document was produced because it was considered to be communications that we had with providers about anesthesia and that was one of the things called for in the subpoena.

Q Okay. Then could you identify Exhibit 1027 for me which also came from your files?

A It's a Medicare newsletter that was issued in August of 1991.

Q And I have a few questions about the bottom part of the second page, anesthesiologist and CRNA – Single Service. [28] Could you take a moment to review that paragraph?

A (Examining document.)

Q Let me know when you're ready.

A All right.

Q Can you tell me what the background is to the publication of this paragraph, how this set of CPT codes came about?

A We had been advised by anesthetist providers as I recall that Blue Shield had come up with a list of procedure codes that they would assume medical necessity for both the anesthetist and the anesthesiologist's involvement and the request was that we would agree to the same list and we did and then published it.

Q So these are procedure codes on which Travelers considered and would reimburse for medically necessary CRNA services in addition to an anesthesiologist's service?

A That's correct.

Q And that would be on cases where there was no concurrent case? Correct?

A That's also correct.

Q All right. Did Travelers ever issue any instructions to providers as to – let me start over. Am I correct that there are two modifiers under which CRNAs could

bill, one for medically directed services and one for [29] nonmedically directed services?

A That's correct.

Q Did Travelers ever issue any instruction as to which modifier CRNAs were to use in billing for these medical necessity cases?

A No.

Q Was it your understanding that the services would be billed using the medically directed modifier?

A That's correct.

Q And am I also correct that Travelers would reimburse at two different rates for CRNA services, a medically directed rate and a nonmedically directed rate?

A That's correct.

Q And what reimbursement rate were CRNA services on medical necessity cases reimbursed?

A I don't recall what it was at that time.

Q Has it changed over time?

A Yes.

Q So at one time it was the nonmedically directed and at one time it was the medically directed rate?

A I'm sorry. I misunderstood the original question I think.

Q Okay. Let's go back. Medicare reimburses for CRNA services at one of two rates, medically directed or nonmedically directed? Is that correct?

[30] A That's correct.

Q Okay. With regard to those medical necessity cases that are discussed in Exhibit 1027, which rate did Travelers reimburse for CRNA services at?

A The medically directed rate.

Q Okay. And that policy has been consistent over the time since 1989?

A Yes.

(Discussion off the record between Attorney Fraser and Attorney Duncan.)

Q (By Mr. Duncan, continuing) Mr. Fraser raised a question with me here. In Exhibit 1026 I see that the little Bates numbers, the small numbers go 846, 847, 848 but the pages seem to be 1, 3 and 5. Did you intend to produce any more of this exhibit?

A I think there's a page missing.

Q Which page would that be?

A Our page 2.

Q Okay. Maybe we can get that during a break.

MR. STONE: Can I make a suggestion that maybe this was a double-sided document and you forgot to copy the sides of pages 1 and 3.

A I didn't personally copy them.

MR. STONE: I don't mean you. I mean Travelers, whoever did it.

* * *

Supreme Court, U.S.
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No. 02-27

In The

Supreme Court of the United States

ALLINA HEALTH SYSTEM CORP., ET AL.,

Petitioners,

v.

UNITED STATES OF AMERICA, EX REL. MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

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INTRODUCTION

While briefing of the petition for a writ of certiorari was under way in this action, the Court granted certiorari in case number 01-1572, *Cook County v. United States ex rel. Chandler*. Although the outcome in *Cook County* will not be directly dispositive of this action, the grant of certiorari in that case emphasizes the significance of the threshold jurisdictional determination of who can be a party to a civil qui tam action under the False Claims Act, 31 U.S.C. §§ 3729-3733 ("FCA" or "Act"). Pursuant to Supreme Court Rule 15.8, petitioners file this supplemental brief in support of their petition, respectfully suggesting that certiorari should be granted here to address a companion jurisdictional issue to that presented in *Cook County*. Petitioners also suggest that this action would be an appropriate one to consider joining with *Cook County* for oral argument.[1]

ARGUMENT

The question presented in *Cook County* is whether local governmental entities, in the form of a public hospital, are subject to qui tam actions under the FCA, 31

[1] Petitioners Allina Health System, et al., filed their petition for a writ of certiorari on June 24, 2002. The Court granted the petition of Cook County in case no. 01-1572 on June 28, 2002. Petitioners were not aware of the grant of certiorari in case no. 01-1572 until after they filed the reply brief in support of their petition on August 19, 2002. Opening briefs in *Cook County* are scheduled to be filed on September 9, 2002, while this case is calendared for conference on September 30, 2002, making a joint briefing schedule for the two cases not feasible.

U.S.C. § 3729. The answer to this question turns on whether local governmental entities fall within the definition of "any person," 31 U.S.C. § 3729(a), subject to liability for knowingly presenting or causing to be presented a false claim to the government. *See* Petition for a Writ of Certiorari of Cook County (Feb. 19, 2002) ("Cook County Pet.") 6-8; 12.

A dispositive question of federal jurisdiction based on statutory interpretation also exists in this case, namely whether an incorporated trade association, respondent Minnesota Association of Nurse Anesthetists ("MANA"), can be an "original source" under the Act, 31 U.S.C. § 3730(e)(4)(B), entitled to bring a qui tam action that is based upon publicly disclosed allegations of false claims. Petition for a Writ of Certiorari of Allina Health System, et al. (June 24, 2002) ("Pet.") 7-16. Answering that question turns in large part on determining whether MANA is "an individual" under the FCA's definition of original source, 31 U.S.C. § 3730(e)(4)(B), which ultimately involves interpreting the same sources of law needed to answer the question presented in *Cook County*.[2]

The statutory term "person" is used in both 31 U.S.C. § 3729 and § 3730, but is specifically defined in neither section. Both Cook County and the petitioners here rely on the analysis of the Court in *Vermont Agency of Natural*

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[2] Factually, *Cook County* and this case both involve an industry, the provision of health care, which has become a recognized locus of FCA qui tam actions. *See* Pet. 6-7. Both cases attracted substantial *amicus* support at the petition stage from hospitals around the nation, attesting to the significance of the lower court decisions at issue to public and private hospitals.

Resources v. United States ex rel. Stevens, 529 U.S. 765 (2000), as a guide to statutory interpretation of the jurisdictional provisions of the FCA. *Stevens*, in turn, looked to the FCA's "sister scheme," the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812 ("PFCRA"), for a definition of "person" suitable for use in interpreting that term in the FCA, 31 U.S.C. § 3729. *See* 529 U.S. at 786 and 31 U.S.C. § 3801(a)(6) (PFCRA definition of "person" as "any individual, partnership, corporation, association or private organization"). Cook County argues that local governmental entities do not fall within the scope of this definition of "person," Cook County Pet. 21-23, while the petitioners here argue that, under this definition of "person," the incorporated trade association MANA cannot be considered "an individual" able to proceed as an original source relator.[3] Pet. 9-13.

Hearing this case and *Cook County* jointly would provide the Court an opportunity to address definitively questions left open after *Stevens* of who can bring qui tam actions under the False Claims Act and who can be targeted by them.

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[3] Even the dissent in *Stevens* acknowledges the distinction between "private individuals and corporations" in "general statutory references to 'persons,'" 529 U.S. at 780 fn.9 (majority op., quoting 529 U.S. at 790, J. Stevens, dissenting).

CONCLUSION

Petitioners respectfully request that the petition for a writ of certiorari be granted and that the Court consider hearing argument in this action jointly with *Cook County*.

Dated: September 9, 2002

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